STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155109		06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MISHAWAKA	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	This visit was for the Investigation of Complaint # IN00173996. Complaint #IN00173996 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226 and F323. Survey dates: June 1, 2 and 3, 2015 Facility number: 000045 Provider number:155109 AIM number: 100291400 Census bed type: SNF/NF: 63 Total: 63 Census payor type: Medicare: 3 Medicaid: 56 Other: 4 Total: 63 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**Disclaimer Statement** Submission of the plan of 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. **"This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirement."**	
F 0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			

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.

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SS=D Bldg. 00	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. Based on record review and interview, the facility failed to ensure an allegation	F 0225	**F225-D Investigate/Report Allegations/Individuals** The	06/24/2015

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

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	of verbal abuse was reported to the appropriate state agency timely for 1 of 3 unusual occurrences reviewed. (Resident B) Finding includes: On 6/2/15 at 12:30 P.M., a facility Grievance Form, provided by the Director of Nursing, was reviewed. The grievance form indicated, but was not limited to,"...Resident Name: Resident B...Today's Date: 5/16/15...Grievance was voiced by Individual [Resident B's daughter's name]...Statement of Concern: Roommate stated two aides were mean to her mother during care...Action Plan: Start investigation interviewed [names of certified nursing assistants] interviewed roommate and Resident B...Investigating Associate's Signature: [Executive Director's name]...Nature of Resolution: Findings were that the aides talked louder so Resident B could hear over her ramblings. Aides instructed to be mindful of roommate during early morning hours...." On 6/2/15 at 2:00 P.M., an investigation, dated 5/15/15, was reviewed. The investigation included the following, "...Roommate stated to Resident B's family that staff were mean to her. Verbally?? [Roommate]: Ask what 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in process. 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	

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	aides were saying that was mean. Stated they sounded mean[(woke her up] they were talking loud...Roommate stated she heard aides speak loud to her early this AM. Asked how it compared to how I [Executive Director] spoke to her the night before stated it was the same...." On 6/2/15 at 2:20 P.M., an interview was conducted with the Executive Director. The Executive Director indicated she was the one who did the investigation of the grievance filed by Resident B's daughter. The Executive Director (E.D.) indicated she was down in Resident B's room in the late afternoon of 5/15/15, Resident B was talking in a louder tone of voice and the staff were having a hard time getting her to hear what they were trying to say to her so they were talking louder in an attempt to talk over her. The Executive Director further indicated she herself was talking in a louder than normal voice in order for Resident B to hear the E.D., so when the E.D. was conducting the investigation the next day she thought that perhaps this is what Resident B's roommate was describing when she indicated they [staff] were mean to Resident B and talked loud. The Executive Director indicated she had interviewed the staff that had worked the night shift and they had indicated on the night the allegation was made, Resident		incident, and if the alleged violation is verified appropriate corrective action must be taken. 1) Resident B was observed and interviewed 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. Individual adjustments to care plans were made as appropriate. 3) The facility abuse policy and procedure was reviewed. The Director of Clinical Education and/or Designee will in-service all staff related to following facility policy and procedure with any allegation of abuse to prevent potential further abuse while the investigation is in process and to insure that all allegations of abuse are reported to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency). 4) The DNS and/or designee will audit progress notes and 24 hour report sheets to insure allegations of abuse are followed up on according to facility policy and procedure. Each guardian angel will conduct interviews with assigned residents during guardian angel rounds and report any allegation of abuse reported by residents to the ED for appropriate follow up. Audits and	

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	B was hard to redirect, she had been attempting to take off her boot and get out of bed. The staff indicated Resident B did not want to believe what the staff were telling her. The Executive Director believed this was due to "Sundowners." When Resident B's roommate was interviewed, the E.D. asked her to describe the way the staff talked to Resident B by asking how it [the loud voice] compared to the way she spoke to Resident B the evening before and the roommate indicated it was the same. The E.D. indicated she felt at the time it wasn't an allegation of abuse it was talking with a louder than normal voice in order to get the Resident being spoken to to hear what staff were trying to say to her. She further indicated she did not report the allegation. On 6/2/15 at 3:15 P.M., a current policy, provided by the Executive Director and titled " Reporting Alleged Violation," revised 2013, was reviewed. The policy indicated but was not limited to, "...It is the policy of this center to take appropriate steps to prevent the occurrence of : abuse, neglect, injures of unknown origin, and misappropriation of resident property...The center investigates each such alleged violation thoroughly and reports the results of all investigations to the Executive Director		interviews will be performed at a minimum of at least five times per week for a minimum of at least 90 days or 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, 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.	

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	or his or her designee, as well as to state agencies as required by state and federal law...." This Federal tag relates to Complaint #IN00173996. 3.1-28(c)			
F 0226 SS=D Bldg. 00	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 record review and interview, the facility failed to implement their policy by not ensuring an allegation of verbal abuse was reported to the appropriate state agency timely for 1 of 3 unusual occurrences reviewed. (Resident B) Finding includes:	F 0226	**F226-D Develop/Implement 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. 1) Resident B was observed and interviewed and no ill effects were observed related to the deficient practice. 2) All residents have	06/24/2015

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	On 6/2/15 at 12:30 P.M., a facility Grievance Form, provided by the Director of Nursing, was reviewed. The grievance form indicated, but was not limited to,"...Resident Name: Resident B...Today's Date: 5/16/15...Grievance was voiced by Individual [Resident B's daughter's name]...Statement of Concern: Roommate stated two aides were mean to her mother during care...Action Plan: Start investigation interviewed [names of certified nursing assistants] interviewed roommate and Resident B...Investigating Associate's Signature: [Executive Director's name]...Nature of Resolution: Findings were that the aides talked louder so Resident B could hear over her ramblings. Aides instructed to be mindful of roommate during early morning hours...." On 6/2/15 at 2:00 P.M., an investigation, dated 5/15/15, was reviewed. The investigation included the following, "...Roommate stated to Resident B's family that staff were mean to her. Verbally?? [Roommate]: Ask what the aides were saying that was mean. Stated they sounded mean[(woke her up] they were talking loud...Roommate stated she heard aides speak loud to her early this AM. Asked how it compared to how I [Executive Director] spoke to her the		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. 3) The facility abuse policy and procedure was reviewed. The Director of Clinical Education and/or Designee will in-service all staff related to following facility policy and procedure with any allegation of abuse to prevent potential further abuse while the investigation is in process and to insure that all allegations of abuse are reported to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency). 4) The DNS and/or designee will audit progress notes and 24 hour report sheets to insure allegations of abuse are followed up on according to facility policy and procedure. Each guardian angel will conduct interviews with assigned residents during guardian angel rounds and report any allegation of abuse reported by residents to the ED for appropriate follow up. Audits and interviews will be performed at a minimum of at least five times per week for a minimum of at least 90 days or until no further issues are noted. Issues noted will be reported to the IDT team in morning meeting for review and	

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	night before stated it was the same...." On 6/2/15 at 2:20 P.M., an interview was conducted with the Executive Director. The Executive Director indicated she was the one who did the investigation of the grievance filed by Resident B's daughter. The Executive Director (E.D.) indicated she was down in Resident B's room in the late afternoon of 5/15/15, Resident B was talking in a louder tone of voice and the staff were having a hard time getting her to hear what they were trying to say to her so they were talking louder in an attempt to talk over her. The Executive Director further indicated she herself was talking in a louder than normal voice in order for Resident B to hear the E.D., so when the E.D. was conducting the investigation the next day she thought that perhaps this is what Resident B's roommate was describing when she indicated they [staff] were mean to Resident B and talked loud. The Executive Director indicated she had interviewed the staff that had worked the night shift and they had indicated on the night the allegation was made, Resident B was hard to redirect, she had been attempting to take off her boot and get out of bed. The staff indicated Resident B did not want to believe what the staff were telling her. The Executive Director believed this was due to "Sundowners."		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.	

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	When Resident B's roommate was interviewed, the E.D. asked her to describe the way the staff talked to Resident B by asking how it (the loud voice) compared to the way she spoke to Resident B the evening before and the roommate indicated it was the same. The E.D. indicated she felt at the time it wasn't an allegation of abuse it was talking with a louder than normal voice in order to get the Resident being spoken to to hear what staff were trying to say to her. She further indicated she did not report the allegation. On 6/2/15 at 3:15 P.M., a current policy, provided by the Executive Director, and titled "Reporting Alleged Violation," revised 2013, was reviewed. The policy indicated but was not limited to, "...It is the policy of this center to take appropriate steps to prevent the occurrence of : abuse, neglect, injures of unknown origin, and misappropriation of resident property...The center investigates each such alleged violation thoroughly and reports the results of all investigations to the Executive Director or his or her designee, as well as to state agencies as required by state and federal law...." This Federal tag relates to Complaint #IN00173996.			

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	3.1-28(a)			
F 0323 SS=G Bldg. 00	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, record review and interview, the facility failed to provide adequate supervision to prevent an accident that resulted in the resident sustaining blistering burns to her breast and abdomen that required ongoing treatment and assessment for healing and prevention of infection for 1 of 1 residents reviewed for accidents. (Resident B) Finding includes:	F 0323	**F323-E Free of Accidents/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. 1) Resident B was reviewed and has had no further ill effects related to the deficient practice. The blisters resulting from the coffee spill continue to heal. 2) An audit of current	06/24/2015

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	On 6/2/15 at 9:05 A.M., the clinical and electronic medical record for Resident B was reviewed. Resident B was admitted to the facility, on 11/19/14. The diagnoses included, but were not limited to, "...Alzheimer's disease, senile dementia with depressive features, secondary diabetes mellitus with other specified manifestations uncontrolled, congestive heart failure unspecified and occlusion and stenos carotid art w/o mention infarct...." The MDS (Minimum Data Set) assessment, dated 3/23/15, indicated a BIMS (Brief Interview for Mental Status) of 2 out of a possible 15, which indicated severe cognitive impairment. Resident B required one person physical assist for eating her meals. Review of the Certification of Investigation, dated 5/17/15, indicated, "...Location Event Occurred: Resident's Room...Date/Time of Occurrence 5/17/15 at 18:37 [6:37 P.M.]...Provide A Detailed Description of Event/Allegation: during supper on Sunday evening resident spilled coffee to her left breast, when area was assessed later found several fluid filled blisters to left breast and to an area slightly under her left breast...Assessment of Resident/Describe Injury: found an		residents who require assistive devices with dining was completed to ensure that no other residents were affected by this practice. Individual adjustments to care plans were made as appropriate. 3) The Director of Clinical Education/Designee will in-service licensed staff regarding the need to ensure residents who require assistive devices are given the staff's complete attention when dining. 4) The Director of Nursing/Designee will monitor residents' need for assistive devices at a minimum of five times per week at various meals to ensure all residents who utilize assistive devices are being given staff's complete attention during dining services. Monitoring will occur for a minimum of at least 90 days or until no further issues are noted. Issues noted by the Director of Nursing/Designee will be reported to the IDT team in morning meeting for review and corrective action as needed. 5) Any concerns will be monitored through 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	

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	area to her left breast that is slightly pink in color measures 6 x 4 cm [centimeters]with several fluid filled blisters measuring from 0.2 x 0.2, 1 x 1, and an L shaped area with 3 fluid filled blisters largest 3.8 x 1 cm and smallest is 2 x 1.2 cm and and area slightly under left breast that is slightly raised and slightly pink in color measures 7 x 10 cm with several fluid filled blisters smallest measures 0.2 x 0.2 cm largest measures 2.2 x 2.3 cm...Resident Interview Summary: i spilled my coffee... Immediate Resident Protection Initiated: when she spilled the coffee at supper a cool compress was applied and resident encouraged to not rub or touch area, but was frequently found rubbing area...Causal/Contributing Factors and Observations: was told by [name of certified nursing assistant #1] that resident takes the top of her cup at times and she falls asleep at times at meals... Specify Recommendations/Interventions Taken To Prevent Reoccurrence: resident should not have hot liquids on her own...." Review of a Progress Note, dated 5/17/15 18:37 (6:37 P.M.), indicated, "...Situation: during supper resident picked up her coffee cup on her own to take and drink and spilled it down the left side of her chest...Background:		time monitoring will be decreased to an as needed basis as determined by the QAPI committee.	

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

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	Dementia, chronic pain, anxiety, needs assist with ADL"s...Assessment: resident called out her breast hurt, staff went to see why resident was calling out, noted her shirt was wet on the left side, resident stated she spilled her coffee, coffee was in a cup with a lid, shirt was removed and area checked, noted a area of approximately 6 x 4cm slightly pink to her left breast and nipple, cool compress was applied, resident continue complains of pain, TLC [tender loving care] given, taken to her room and put to bed, daughter was informed...Responses: MD [medical doctor] and daughter informed of spill, no new orders...." Review of a Progress Note, dated 5/17/15 at 21:12 (9:12 P.M.) indicated, "... resident resting now, assessed area to left breast, breast continues with a slightly pink area, and now has a slightly pink area to her chest under her left breast , area is 7.5 x 6 cm...." Review of a Progress Note, dated 5/18/15 at 1:11 A.M., indicated "... follow up spilled coffee, now has several fluid filled blisters to breast and to area under left breast, entire area to left breast is slightly raised measures 6 x 4cm, has 2 small fluid filled blister above the nipple measuring 0.2 x 0.2 cm, to the right of the nipple and slightly above is a slightly			

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	filled blister 1 x 0.6 cm, to the right and below the nipple area fluid filled blister measures 1 x 1 cm, and to the left and slightly below the nipple is an L shaped area with 3 fluid filled blisters top measures 2.7 x 1 cm, middle one measures 2 x 1.2 cm and the lower one measures 3.8 x 1 cm, the area slightly below her breast is slightly raised and slightly pink measures 7 x 10 cm, has several different sizes of fluid filled blisters, 4 of them measure 0.2 x 0.3 cm, 0.5 x 0.5 cm, 1.7 x 1cm, 1.6 x 0.8 cm, 1.8 x 1cm, and the largest measures 2.2 x 2.3 cm, resident shows no signs of pain or discomfort at this time...." Review of Physician's Order, dated 5/18/15 at 11:56 A.M., indicated, "... Cleanse blisters to left breast and below left breast gently with normal saline, apply bacitracin to blisters and reddened areas in thin layer, cover with ABD's to completely cover areas. Change BID [twice daily] and PRN [as needed] until resolved...." On 6/2/15 at 10:00 A.M., an observation of the blisters was conducted with the Director of Nursing Services (DNS) while she did wound rounds. 3 areas were observed on the left side of the resident the 1st was located just below her left breast, the 2nd just below on the			

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	abdomen and the 3rd on the lower part of the abdomen off to the side. Each of the areas were circular in shape with brown scabbing and yellow slough. The two larger blisters had a small amount of yellow drainage when the old bandage was removed. Each of the blisters had pink surrounding tissue noted with no odor or other indicators of infection. Each blister was treated with Bacitracin (an antibiotic ointment) and covered with an ABD (dressing) pad. During an interview with the DNS conducted at that time, the DNS indicated Bacitracin was clinically indicated related to Resident B's allergy to Sulfa drugs which is a component in the medication normally used to treat burns. On 6/2/15 at 12:00 P.M., an observation was made of Resident B in her room eating her lunch. Resident B's food was served on a divided plate with white weighted looking utensils and she had a brown cup with a white plastic lid on top of it with a small straw sticking out of it. CNA #2 was cueing and assisting Resident B to eat and drink. On 6/2/15 at 3:47 P.M., an interview was conducted with CNA #2. CNA # 2 indicated that Resident B took her meals in the Fireside diningroom where her meals were supervised because she			

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	needed cues to eat. CNA # 2 indicated when Resident B was alert she would feed herself and hold the cup and drink the coffee. "... She loved her black coffee no cream/no sugar when she was alert she would take the lid off of her coffee she didn't want help and wanted to still be in control...." On 6/2/15 at 4:10 P.M., an interview was conducted with CNA # 3. CNA #3 indicated that Resident B ate her meals in the Fireside diningroom. "...Fireside diningroom is an assisted diningroom. We go from table to table to feed resident's. Resident B loves coffee. We would put a lid on her coffee cup and she would take the lid off on occasion and move her drinks around...." On 6/3/15 at 2:03 P.M., an interview was conducted with the Director of Nursing Services. The Director of Nursing Services indicated there was no policy related to hot liquids but that anyone who eats in the assisted diningroom had a lid placed over their hot liquids for safety. The Director of Nurses further indicated she was not made aware that Resident B had a history of removing the lid from her coffee cup she indicated she would expect her staff to report that to her so that the facility could assess Resident B's needs, care plan and potentially provide			

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	Resident B with a cup for her hot liquids that she could not remove the lid. On 6/3/15 at 2:17 P.M., an interview was conducted with the 100 Hall Unit Manager. The Unit Manager indicated that it had not been reported to her that Resident B had a history of removing the lid from her coffee cup. She further indicated that if she would have known she could have implemented an alternative plan for her. On 6/3/15 at 2:30 P.M., a Kardex (a tool used by the CNA's to alert them to the care needs of a resident) for Resident B was reviewed. The Kardex indicated "...Lid on cup all hot liquids and staff supervision...." On 6/3/15 at 2:45 P.M., a current policy, provided by the Director of Nursing Services and titled, Feeding the Resident (Dependent Eating), and effective May 2011, was reviewed. The policy indicated, "...The purpose of feeding the resident who needs assistance is to: Assist the resident with feeding as necessary...General guidelines for assessment may include, but are not limited to: Need for assistive devices...Diet as ordered...Assistive Devices as needed...Give the resident your complete attention...."			

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