

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 03/27/2015
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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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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 23, 24, 25, 26 and 27, 2015</p> <p>Facility number: 000045 Provider number: 155109 AIM number: 100291400</p> <p>Survey team: Julie Baumgartner, RN-TL Shauna Carlson, RN (3/23, 3/24, 3/25 and 3/26, 2015) Pamela Williams, RN Amy Miller, RN (3/26 and 3/27, 2015) Lora Swanson, RN (3/27/15)</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 3 Medicaid: 57 Other: 2 Total: 62</p>	F 000	<p><u>Disclaimer Statement</u> 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."</p>	

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.

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F 242 SS=D Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on April 7, 2015, by Brenda Meredith, RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure a residents choices and preferences were honored related to being able to choose what to wear in the morning. (Resident #17)</p> <p>B. Based on interview and record review, the facility failed to honor the preferences for bathing for 2 of 3 residents reviewed for bathing preferences. (Resident #6 and Resident #43)</p> <p>Findings include:</p>	F 242	<p>F242-D Self Determination - Right to Make Choices The resident has the right to choose activities, schedules and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>1) Resident #17, #6, and #43 were assessed and no ill effects were observed related to the deficient practice. Resident #17 is choosing her on clothing in the AM. Resident #6 is being given a</p>	04/26/2015

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	<p>A.1. On 3-24-15 at 10:45 A.M., during an interview, Resident #17 indicated when the aides get her up in the morning, they go to her closet and pick out clothes and put them on her. "When I was at home, I picked my own clothes...I'd like to do that here...."</p> <p>On 3-24-15 at 2:30 P.M., a review of Resident #17's record was conducted. Her diagnoses included, but were not limited to, depressive disorder, urinary tract infection, cognitive communication deficit, anemia, malaise and fatigue, and chronic pain syndrome. Review of the MDS (Minimum Data Set) assessment, dated, 3-22-15, indicated a BIMS (Brief Interview for Mental Status) of 10 out of a possible 15, indicating moderate cognitive impairment.</p> <p>On 3-25-15 from 6:12 A.M. to 6:26 A.M., CNA (Certified Nursing Assistant) #16 was observed to get Resident #17 out for bed for the day and complete her morning hygiene routine. CNA #16 went to Resident #17's closet and picked out a pair of pants and a blue floral shirt and laid them on Resident #17's wheelchair. After helping Resident #17 get washed up, CNA #16 assisted Resident #17 into her clean clothes for the day without ever asking her what she would like to wear for the day.</p>		<p>bed bath per his preference. Resident #43 is being given showers at the frequency she prefers. 2) All residents have the potential to be affected by this practice. An audit of all residents to ensure showers/bed baths are given based on individual preference and clothing is determined by resident preference was completed to ensure that no other residents were affected by this practice. Individual adjustments were made as appropriate. 3) All nursing staff will be in-serviced regarding the need to ensure resident preference is honored regarding choice of clothing and bathing. 4) Management staff will monitor assigned rooms at a minimum of at least three times per week during Guardian Angel Rounds to ensure resident preferences are being honored. Issues/concerns noted will be reported to the Director of Nursing and/or Designee, the Executive Director and/or Designee and the IDT team in morning meeting for review and corrective action as needed. The Executive Director and/or Designee will follow up to ensure any concerns/issues have been addressed at a minimum of at least three times per week until concerns/issues with resident preference being honored are no longer noted. 5) Any concerns will be monitored through the QAPI process for a minimum of</p>		

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	<p>On 3-25-15 at 9:34 A.M., an interview with the DON (Director of Nursing) was conducted. The DON indicated the CNA's are expected to give the resident a choice about what to wear for the day.</p> <p>On 3-25-15 at 9:40 A.M., an interview with the MDS nurse was conducted. The MDS nurse indicated sometimes the CNA's won't ask the very confused residents about what they want to wear since they wouldn't be able to verbalize their choice, but a resident with a BIMS of 10 would be able to choose and should be given a choice.</p> <p>On 3-25-15 at 10:25 A.M., during an interview, the DON indicated they did not have a policy specific to resident's being able to choose what they wear during the day.</p> <p>B.1. During an interview, on 3-24-2015 at 11:19 A.M., Resident #6 indicated he did not get to choose if he receives a shower or a sponge bath. Resident #6 indicated they (staff) ask him every time if he wants to take a shower and he doesn't want one but feels pressured to take one because they keep asking. Resident #6 indicated he usually takes a sponge bath at home. Resident #6 indicated, "I took a shower the other day</p>		<p>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>	

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	<p>and it felt like my skin was coming off...I told them I don't like showers."</p> <p>On 3-24-2015 at 12:10 P.M., record review of the "CNA Shower Skin Flow Sheet" received from the DON as the current tool used by the CNA's during showers, indicated, "...Shower given? Yes No If no, did resident refuse? Yes No...Reason given for refusal? ...Shower offered x [times] 2? Yes No...." The DON indicated that the CNA's are instructed to offer showers times 2 before offering a bed bath because showers are the best way to get clean and we try to encourage all our residents to take a shower over a bed bath. We do have one resident who doesn't like showers but we did get her to take one last month because we keep asking. We do not have a policy or procedure related to showers.</p> <p>On 3-25-2015 at 5:00 A.M., record review of Resident #6's MDS Kardex Report (CNA assignment sheet) indicated, "Resident prefers a BB [bed bath]." During an interview, at this time, CNA #14 indicated, "...We offer a shower to everyone and if they refuse, we let the charge nurse know about it, then that person can be put down as a bed bath instead and we don't have to offer a shower twice before giving a bed bath, we know it is there preference...I do not</p>			

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	<p>look at the Kardex's for the residents bathing preferences, I look at the shower sheets to see if the resident has a preference and he [Resident #6] is a shower on the shower sheet...he [Resident #6] prefers a bed bath on the Kardex...I didn't know that...the other day he [Resident #6] told me that he [Resident #6] felt like his skin was coming off in the shower...."</p> <p>On 3-26-2015 at 11:10 A.M., record review of the "Basic Rights" booklet, received from the Executive Director as the booklet given as part of the admission process to all new resident, indicated, "...Basic Rights... You have the right to be treated with respect and dignity in recognition of your individuality and preferences...."</p> <p>During an interview, on 3-26-2015 at 1:37 P.M., the DON indicated, "...we don't have a system in place to assess for bathing preferences because we like everyone to take a shower...if the resident has a good enough reason, we would not ask them to take a shower and just give them a bed bath...."</p> <p>B. 2. During an interview on 3/24/15 at 11:59 A.M., Resident # 43 indicated "I just get a shower twice a week... I would like one more often...even daily...."</p>			

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	<p>During an interview, on 3/25/15 at 5:23 A.M., LPN # 13 indicated "I don't know that we assess a resident for how many showers or bed baths they want...when you are admitted you are assigned to a room and you get a shower 2 times a week on the days assigned to that room number...."</p> <p>On 3/25/15 at 6:33 A.M., a clinical record review was conducted for resident #43.</p> <p>The MDS assessment, dated 2/9/15, indicated the BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. Review of the residents MDS Kardex report did not indicate if the resident preferred showers or bed baths or the frequency of them. Review of the CNA (Certified Nursing Assistant) shower sheet indicated Resident #43 received a shower 2 times per week.</p> <p>During and interview on 3/25/15 at 9:25 A.M., the DON indicated "...nursing schedules the showers...the routine shower schedule is twice a week... a resident is always scheduled for twice a week....the MDS Kardex is how the CNA's get the residents assignments including shower preference and frequencies...."</p>			

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F 258 SS=E Bldg. 00	<p>During an interview on 3/27/15 at 3:30 P.M., the DON indicated "I did not know Resident #43 wanted showers 7 days a week...."</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels.</p> <p>Based on observation and interview, the facility failed to ensure comfortable sound levels were maintained on the 200 hall. This having the potential to effect 32 of 32 residents on the 200 hall in the total census of 62.</p> <p>Finding includes: On 3/24/15 at 11:19 A.M., an</p>	F 258	<p>F258-D Maintenance of Comfortable Sound Levels The facility must provide for the maintenance of comfortable sound levels. 1) Resident #6 and #32 were assessed and no ill effects were observed related to the deficient practice. 2) All residents on the 200 hall were assessed and no ill effects were observed related to the deficient practice. 3) The nursing staff will be in-serviced on the need to maintain comfortable sound</p>	04/26/2015

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	<p>observation was made of the 200 hall nurse crushing medications with a manual pill crusher causing a loud knocking noise. Resident #6 indicated "... I thought some on was knocking again...."</p> <p>During an interview on 3/24/15 at 11:26 A.M., Resident #6 indicated "... it's noisy in the hallway...loud at night...residents and CNA's [Certified Nursing Assistants] shouting in the hall...."</p> <p>During an interview on 3/24/15 at 1:45 P.M., Resident #32 indicated "...sometimes it's noisy at night...trash barrels make a lot of noise and staff yells down the hall...."</p> <p>On 3/25/15 at 4:00 A.M., an observation was made of the 100 and 200 halls. The following was observed: Radio on at 200 hall nurses station. Room A, resident awake, room door open, television on loud and able to be heard at 200 hall nurses station. Room B Bed 1 television on loud, room door open, television able to be heard at 200 hall nurses station. Room C Bed 2 television on loud, room door open, able to be heard at 200 nurses station. Room D Bed 1 and 2 television on loud, room door open, able to be heard at 200 hall nurses station.</p>		<p>levels. 4) The DNS and/or Designee will audit sound levels on the 200 hall on all shifts to ensure comfortable sound levels are being maintained. Audits will be performed at a minimum of at least three 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>	

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F 279 SS=D Bldg. 00	<p>During an interview on 3/27/15 at 10:05 A.M., the DON (Director of Nursing) indicated " ... the halls can be noisy at times...I expect the staff to talk quietly in the hallway at night... staff should keep sound levels as quite at possible... nurses should be using the automatic pill crusher not the manual...televisions should be turned down at night so they don't disturb others... we prefer that after 9 P.M., the noise needs to be at a level that will not disturb your room mate...."</p> <p>During an interview on 3/27/15 at 2:00 P.M., the DON indicated we do not have a policy on noise levels.</p> <p>3.1-19(f)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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</p>			

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	<p>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 record review and interview, the facility failed to ensure that a care plan was developed related to pain (Resident #54), and UTI (Urinary Tract Infection) (Resident #60) for 2 of 17 residents reviewed for care plans.</p> <p>Findings include:</p> <p>1. During an interview on 3/23/15 at 3:12 P.M., Resident # 54 indicated "I have chronic pain...but is relieved with medications...."</p> <p>On 3/25/15 10:35 A.M., a clinical record review was conducted for resident #54. Diagnoses include, but not limited to, "Chronic Pain, Bone Ca [Cancer] Metastasis, Multiple Myelome w/o [without] Mention of Remission...." Review of the MDS (Minimum Data Set) assessment, dated 2/2/15, indicated the BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. There was no care plan was developed related to pain.</p>	F 279	<p>F279-D Develop Comprehensive Care Plans A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). 1) Resident #54 and #60 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</p>	04/26/2015

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	<p>The Quarterly Interdisciplinary Resident Review, dated 1/8/15, provided by the DON for Resident # 54, indicated, "Pain... Pain Rating Score 6...Descriptors: Aching...Throbbing...Does pain impact quality of life/functioning? ...Yes... Limits Activity...."</p> <p>The medication administration record for March 2015 provided by the DON (Director of Nursing) indicated medications include but not limited to: Norco 10-325 mg [milligrams] 1 tab [tablet] every 6 hours related to Other Chronic Pain... Fentanyl Patch 72 hour 50 MCG [microgram]/ HR [hour]... Gabapentin Capsule 300 MG give 1 capsule three times daily related to Pain in Thoracic Spine... MS [Morphine Sulfate] Contin Tablet Extended Release 30 MG Give 1 tablet by mouth every 8 hours related to Pain in Thoracic Spine...."</p> <p>During an interview on 3/26/15 at 9:40 A.M., the DON indicated "...if a resident has any type of pain they should have a care plan for it"</p> <p>2. On 3/26/15 at 9:00 A.M., a clinical record review was conducted for Resident #60. Diagnosis included but not limited to: Urinary Tract Infection. The</p>		<p>completed to ensure that no other residents were affected by this practice. Care plans were audited and individual adjustments to care plans were made as appropriate/necessary. 3) Licensed Nursing Staff will be in-serviced on 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. 4) The DNS and/or Designee will audit the care plans to ensure care plans 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 identified on a monthly basis until</p>	

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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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F 280 SS=D Bldg. 00	<p>Urinary Culture with Colony Count lab test collected on 1/21/15, indicated, "... Organism 1 Escherichia Coli... Colony Count >1,000,000...." There was no documentation a UTI care plan had been developed.</p> <p>During an interview on 3/26/15 at 10:56 A.M., LPN # 12 indicated " if a resident develops a UTI...a care plan is developed for UTI symptoms... if a antibiotic is ordered we also develop a care plan for antibiotic use then update the UTI symptoms to a UTI care plan...."</p> <p>During an interview on 3/27/15 at 2:00 P.M., the DON indicated "... we do not have a policy specifically related to care plan development and updating...."</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p>		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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	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to update a care plan and place interventions after a fall for 1 of 3 residents reviewed for accidents. (Resident #82)</p> <p>Finding includes:</p> <p>On 3-24-15 at 2:10 P.M., an observation of Resident #82 and his room with no obvious fall interventions to be in place. Resident #82 indicated that he had fallen out of his wheelchair a few weeks ago. Resident #82 indicated he had just woke up and need to use the bathroom and attempted to get out of his wheelchair on his own. Resident #82 did not remember that they had done anything at that time for prevention of falls.</p>	F 280	<p>F280-D Right To Participate Planning Care - Revise CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care must be developed within 7 days after the completion of the comprehensive assessment, prepared by an inter-disciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's</p>	04/26/2015

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	<p>On 3-26-15 at 10:00 A.M., a record review was conducted for Resident #82. Resident #82 was admitted to the facility on 12-23-2014 and diagnoses included, but not limited to, CVA (cerebral vascular accident), depression, and anxiety. The MDS (Minimum Data Set) assessment, dated 12-20-2014, indicated Resident #82 had a BIMS (Brief Interview for Mental Status-a cognitive assessment tool) of 9/15, moderately cognitive intact. A "Verification of Investigation" for a fall that occurred on 3-1-15 at 8:30 A.M. for Resident #82. A care plan for falls for Resident #82, initiated on 12-28-2014 and updated on 3-25-2015, indicated no update or interventions were put in place on or around 3-1-2015.</p> <p>On 3-27-15 at 2:00 P.M., the Director of Nursing indicated, "We don't have a policy specifically related to care plan development and updating." On 3-27-2015 at 3:30 P.M., the Director of Nursing indicated, "We did not update the care plan, I thought we had, we should have."</p> <p>3.1-35(e)</p>		<p>legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 1) Resident #82 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 care plans were made as appropriate/necessary. 3) Licensed Nursing Staff will be in-serviced on the need to review and revise 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 as well as the need to include the resident and/or representative in the development and revision of care plans. 4) The DNS and/or Designee will audit the care plans to ensure care plans have been revised and that the resident and/or representative has participated in the care plan 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</p>		

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F 334 SS=D Bldg. 00	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum,		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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	<p>the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the</p>			

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	<p>resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to ensure a resident who requested a pneumococcal vaccination received it in a timely manner. This deficient practice affected 1 of 5 residents who were reviewed for the pneumococcal vaccination. (Resident #75)</p> <p>Finding includes:</p> <p>The clinical record for Resident #75 was reviewed on 03/26/2015 at 10:15 A.M. Resident #75 was admitted to the facility on 09/23/1014, with diagnoses that included, but were not limited to, anemia, hypertension, diabetes mellitus, CVA (cerebrovascular accident) and depression.</p> <p>A physician's order, dated 09/23/2014, indicated, "Pneumococcal vaccine upon admission to the center...."</p> <p>A facility form titled, "Immunization Record," dated 10/11/14, indicated the pneumococcal vaccine had not been documented as being administered.</p> <p>A facility form titled, "Resident Immunization Consent or Refusal Form," dated 09/23/2014, was signed by Resident #75 and gave consent for the</p>	F 334	<p>F334-D Influenza and Pneumococcal Vaccines The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of the influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the</p>	04/26/2015

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	<p>pneumococcal vaccine.</p> <p>During an interview on 03/26/2015 at 11:55 A.M., the DON (Director of Nursing) indicated the resident was not given the pneumococcal vaccine as ordered and had not yet been given at the time of the interview.</p> <p>3.1-13(a)</p>		<p>benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the immunization due to medical contraindications or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>1) Resident #75 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.</p>	

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			<p>Pneumococcal immunizations were given to qualifying residents. 3) Licensed Nursing Staff will be in-serviced on the need to identify residents who qualify and consent for the pneumococcal immunization as well as the need to obtain a physician's order and administer the pneumococcal immunization to qualifying residents. 4) The DNS and/or Designee will audit all residents to ensure pneumococcal immunizations are administered 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 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</p>	

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F 364 SS=D Bldg. 00	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview and record review, the facility failed to ensure food that was prepared conserved the nutritive value related to pureed food preparation related to 5 of 5 meals prepared. This affected 5 residents receiving a puree diet.</p> <p>Finding includes:</p> <p>On 3/23/15 at 11:40 A.M., during puree meal preparation the following was observed:</p> <p>At 11: 41 A.M., Cook #7 placed 2 pork chops, that he removed off the steam table, into puree machine, mixed them, then added a unmeasured amount of gravy, that he took off the steam table, mixed it again then poured it into pan and placed it on the steam table. At 11:43 A.M., Cook #7 indicated "...for meat I just use my gravy to get desired puree consistency....."</p>	F 364	<p>determined by the QAPI committee.</p> <p>F364-D Nutritive Value/Appear, Palatable/Prefer Temp Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. 1) The five residents receiving a puree diet were assessed and no ill effects were observed related to the deficient practice. 2) All residents receiving pureed diets have the potential to be affected related to the deficient practice. 3) The dietary staff will be in-serviced on the need to follow the recipe when preparing pureed diets. 4) The Dietary Manager and/or Designee will audit the preparation of pureed foods to ensure the recipes are followed during preparation. 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</p>	04/26/2015

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	<p>At 11:49 A.M., Cook #7 placed 3 steaks, that he removed from the steam table, into the puree machine, mixed them, then added an unmeasured amount of gravy that he took off the steam table, mixed it again, poured it into a pan and placed it on the steam table.</p> <p>On 3/26/15 at 3:10 P.M., review of the recipe " Pur [Puree] Braised Pork Chop" provided by the DM [Dietary Manager] indicated "...1. Bring water to a boil...2. Combine hot water and base , mix well...3. Place pureed pre cooked meat in large bowl, add spices...4. Add puree shaper and spices...5. Add very hot broth, mix...13. Serve with 2 oz [ounce] gravy...."</p> <p>On 3/26/15 at 3:15 P.M., review of the recipe " Pur Angus Steak" provided by the DM indicated "...1. Combine boiling water with base , mix well... 2. Heat to very hot...4. Add shape & serve... 5. Add very hot broth and spices... 8. Cover and cook as follows:13. Serve with 2 oz gravy...."</p> <p>During an interview on 3/27/15 at 10:02 A.M., the DM indicated "... when cooks are preparing pureed meals they are expected to follow the recipes...."</p>		<p>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>		

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F 371 SS=F Bldg. 00	<p>On 3/27/15 at 1:40 P.M., review of the current Policy, " Pureed Food Preparation," provided by the DM indicated, "Puree recipes ...Use approved puree recipes for all puree diets... All Living Centers with puree diets are expected to to follow the Enhanced Puree Simple Shape Program...."</p> <p>3.1-21(a)(1)</p> <p>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</p> <p>Based on observation, interview and record review, the facility failed to ensure meals were being served under sanitary conditions in regards to proper use of hairnets, handwashing and food service from 1 of 1 Kitchens. This had the potential to affect 61 of 62 residents.</p> <p>Findings include:</p>	F 371	<p>F371-F 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. 1) Cook #7 was in-serviced on the need to wear a beard net/hair net when in the kitchen; all opened, undated containers as well as all items which were dated past the use by</p>	04/26/2015

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	<p>On 3/23/15 between 10:46 A.M. and 11:50 A.M., during the initial kitchen tour with the DM (Dietary Manager), the following was observed:</p> <p>At 10:46 A.M., Cook #7 was observed in the kitchen at the prep table with no beard net on.</p> <p>In the reach in freezer:</p> <ul style="list-style-type: none"> *An open, undated, box containing 9 deep dish pie shells. *An open, undated, box of assorted doughnuts. *A open, undated bag, containing 8 breadsticks. *An open, undated bag, of pepperoni. <p>On the dry storage shelf across from the reach in freezer:</p> <ul style="list-style-type: none"> *An open, undated, box of yellow cornbread mix. *An open, undated bag of gravy mix. The DM indicated t this time" ...these should have dates...." <p>In the dry storage room:</p> <ul style="list-style-type: none"> *An open, undated, box of Crispy Fry Mix. *An open, undated, bag of French Fried Onions. *An open, undated, box of hot wheat cereal. *An open, undated, bag of sliced 		<p>date were discarded. Dietary Aide #8 was in-serviced on the need to wear her hair net correctly. 2) All residents have the potential to be affected by this practice. An audit of current residents was completed to ensure that no residents were affected by this practice. 3) The Dietary Manager will in-service dietary staff regarding appropriate storage, rotation, and discarding of items to maintain sanitary conditions and follow guidelines, appropriate donning of hairnets and beardnets, and hand washing policy and procedure. The Director of Clinical Education will in-service all staff on proper meal service handling of cups, plates and bowls and hand washing techniques. 4) The Dietary Manager and/or Designee will monitor the kitchen for the appropriate rotation, storage, and discarding of food/food items as well as the appropriate application and usage of hairnets and beard nets and hand washing. 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. The Director of Clinical Education and/or Designee will monitor proper meal service handling of</p>	

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(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>potatoes. *An open, undated, box of mashed potatoes. *An open, undated, bag of elbow macaroni. *An open, undated package of spaghetti. *An open to air, undated, box of lasagna noodles. The DM indicated "... yes these should be dated and the lasagna noodles should be closed and dated...."</p> <p>In the walk in cooler: *An open to air, undated, piece of ham. *An open, undated, piece of boloney. The DM indicated "... yes these should be closed and dated...." *An open, container of heavy whipping cream dated 3/16/15 with a use by date of 3/20/15. The DM indicated "... our policy is use within 7 days...."</p> <p>At 11:20 A.M., Dietary Aide #8 was observed in the kitchen with her hair hanging out the right side of her hair net while washing her hands for 8 seconds then went on to set up drink tray for the noon meal.</p> <p>At 11:25 A.M., Cook #7 was observed washing his hands for 10 seconds then removing food from the oven.</p> <p>At 11:32 A.M., Cook #7 was observed to</p>		<p>cups, plates and bowls and hand washing techniques in the dining rooms. 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>				

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	<p>take his right glove off, lifting the top of the trash can with his gloved hand and throwing the other glove out. Cook #7 then put on a clean right glove and performed meal temperatures.</p> <p>At 11:35 A.M., during food temperatures the following was observed: Cook #7 took temperature for sweet potatoes, wiped probe on disinfectant wipe then took temperature for lima beans, wiped probe on same disinfectant wipe, then took temperature of carrots, wiped probe on same disinfectant wipe, then took temperature of beef, then wiped the probe on same disinfectant wipe, Cook # 7 indicated "... as long as we use a clean spot on the wipe we can reuse the same disinfectant wipe throughout the temping process...."</p> <p>At 11:42 A.M., Cook #7 was observed removing gloves from hands, lifted trash can lid threw gloves away, then put on clean gloves, without washing his hands, he then went on to prepare pureed meals.</p> <p>At 11:48 A.M., Cook #7 was observed removing gloves, throwing them away, putting on clean gloves and then continued with pureed meals.</p> <p>At 11:49 A.M., Cook #7 was observed to place puree mixing bowl in dishwasher</p>			

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	<p>with gloved hands, then removing mixing bowl from dishwasher when done and then proceeded to puree lima beans wearing the same gloves.</p> <p>On 3/23/15 from 12:15 to 12:40 P.M., during the lunch meal the following was observed:</p> <p>At 12:20 P.M., CNA #9 was observed to wash her hands for 8 seconds then place drinking glasses in front of 4 residents by the top edge.</p> <p>At 12 16 P.M., CNA #10 was observed washing her hands for 8 seconds, then served a resident their lunch meal.</p> <p>At 12:24 P.M., CNA #11 was observed washing her hands for 8 seconds then served a resident their lunch meal.</p> <p>At 12: 28 P.M. CNA #6 observed washing hands for 8 seconds, drying her hands with a paper towel, turning off the water with the paper towel, then dried her hands again with same paper towel.</p> <p>At 12:29 P.M., CNA #11 was observed to wash her hands for 8 seconds then served a resident their lunch meal.</p> <p>During and interview on 3/25/15 at 3:08 P.M., the DM indicated hands should be</p>			

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	<p>sanitized after every third tray is passed...hands should be washed for 20 seconds...hands should not touch the food and thumbs should be on the edge of the plate and drinks should be served with hands at the bottom of the glass, not at the top edge or with the palm of the hand over the opening of the cup/glass.</p> <p>On 3/26/15 at 12:10 P.M., review of the current policy, "Infection Control- Dining Services Employee Hair Guidelines," effective date 2/12/15, provided by the DM indicated, "... Complete Coverage ...Hairnets ...must cover all hair completely...Grooming... Keep beards well trimmed.... and covered with an effective hair restraint..."</p> <p>On 3/26/15 at 12: 15 P.M., review of the undated current policy, "Storage of refrigerated Foods and Storage of Frozen Foods," provided by the DM indicated, "Foods Storage... Label and note pull date with use by date on all food items...Rotate stock... [Date per state or county guidelines]"</p> <p>On 3/26/15 at 12:20 P.M., review of the policy, "Handling Clean Equipment and Utensils," effective 2/12/15, provided by the DM, indicated "...Handle clean cups, glasses and bowls so that fingers and thumbs do not contact inside surfaces or</p>			

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	<p>lip contact surfaces...."</p> <p>On 3/26/15 at 12:25 P.M., review of the current undated policy, "Food Temperatures," provided by the DM did not indicate how or when the thermometer should be cleaned.</p> <p>On 3/26/15 at 12:30 P.M., review of the current undated policy, "Handwashing," provided by the DM indicated, "Policy... washing hands ...for a minimum of 20 seconds... Hand-washing procedure...4. Wet hands... 5. Lather hands ...6. Wash hands with vigorous friction...7. Rinse thoroughly... 8. Wipe hands dry... 9. Turn water off with paper towel and dispose of towel"</p> <p>During an interview on 3/26/15 at 3:11 P.M., the DM indicated "... hairnets should cover ever bit of their hair ... beard nets should cover all facial hair and be worn at all times...hands should be washed and gloves should bee changed when moving to a new activity...staff should not open thrash with gloved hand then continue working with food with same gloves.. thermometer probes should be wiped down with new disinfectant wipe after each food temperature taken...do not use same wipe after each temp...hands should be washed for 20 seconds...."</p>				

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F 441 SS=E Bldg. 00	<p>On 3/27/15 at 10:00 A.M., review of the undated current policy, "Storing Dry Food," provided by the DM indicated " ...Opened items... Label all open items with date opened...."</p> <p>3.1-21(i)(1) 3.1-21(i)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>			

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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure a sanitary environment and to help prevent the development and transmission of disease and infection in relation to proper handwashing during medication administration. This had the potential to affect 4 of 4 residents observed for medication administration. (Resident #49, Resident #37, Resident #20, and Resident #69)</p>	F 441	F441-E Infection Control, Prevent Spread, Linens The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	04/26/2015

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	<p>Finding includes:</p> <p>On 3/25/15 from 8:15 A.M. to 8:40 A.M., RN #20 was observed passing medications and the following were observed:</p> <p>At 8:20 A.M., RN #20 was observed to pass medications to Resident #49 in their room and then wash her hands for 4 seconds.</p> <p>At 8:27 A.M., RN #20 was observed to pass medications to Resident #37 in their room and then wash her hands for 9 seconds.</p> <p>At 8:32 A.M., RN #20 was observed to pass medications to Resident #20 in their room and proceed on to passing the next residents medications without washing her hands.</p> <p>At 8:37 A.M., RN #20 was observed to pass medications to Resident #69 in their room and then wash her hands for 10 seconds.</p> <p>On 3-26-15 at 11:16 A.M., the current "Handwashing/Hand hygiene" policy, received from the ED (Executive Director) at this time, indicated "...When to wash hands:...before and after direct resident contact...2. vigorously lather</p>		<p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection; the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. 1) Resident #49, #37, #20, and #69 were assessed and no ill effects were observed related to the deficient practice. 2) All residents have the potential to be affected by this practice. An audit of current residents was completed to ensure that no other residents were affected by this practice. Individual adjustments were made as appropriate. 3) The Director of Clinical Education will in-service all licensed nursing staff appropriate hand washing procedure during medication</p>		

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F 458 SS=E Bldg. 00	hands with soap and rub them together, creating friction to all surfaces, for at least fifteen (15) seconds under a moderate stream of running water, at a comfortable temperature...." 3.1-18(l) 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		pass according to facility policy and procedure. 4) The Director of Nursing Services and/or Designee will monitor hand washing during medication pass to ensure policy and procedure are being followed. 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 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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	<p>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> <p>Findings include:</p> <p>1. During the environmental tour on 3/27/2015 at 10:45 A.M., the following multiple rooms were observed to contain less than 80 square feet per resident. The following rooms were certified SNF/NF 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>	F 458	<p>F458-E Bedrooms Measure At Least 80 Sq Ft/Resident</p> <p>Bedrooms must measure at least 80 Square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. 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>	04/26/2015	

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	<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> <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>			

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	<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. 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>			

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F 999 Bldg. 00	<p>3.1-14 PERSONNEL</p> <p>(u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure three hours of dementia training was completed annually for 2 of 10 employee records reviewed. (Employee #1 and Employee #2)</p> <p>Findings include:</p> <p>On 3/27/15 at 10:00 A.M., review of the</p>	F 999	<p>F9999 Final Observations 3. 1-14 Personnel (u) In addition to the required in-service hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preference, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. 1) Employee #1 and employee #2 have completed annual dementia training. 2) All residents have the potential to be affected by this practice. An audit of current residents was completed to ensure that no other residents were affected by this practice. An audit of completion of dementia training was performed to ensure that all staff as required have completed the dementia training. 3) The Director of Clinical Education and/or Designee was educated on need to ensure all in-servicing is completed as required. 4) The Director of Clinical Education and/or Designee will monitor compliance</p>	04/26/2015

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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			
(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>record for Employee #1 indicated a start date of 2/26/14. A form titled "6 Hours Dementia Training In-Service" indicated Employee #1 received six hours of dementia training on 2/26/14. There was no documentation in the record indicating Employee #1 received an additional three hours of dementia training annually.</p> <p>On 3/27/15 at 10:35 A.M., review of the record for Employee #2 indicated a start date of 10/14/13. A form titled "6 Hours Dementia Training In-Service" indicated Employee #2 received six hours of dementia training on 1/3/14. There was no documentation in the record indicating Employee #2 received an additional three hours of dementia training annually.</p> <p>During an interview, on 3/27/15 at 12:00 P.M., the Human Resources Director (Employee #4) indicated no matter what the employee's initial start date is, we always do our annual inservices in October, so both of these employees are over due for their three hours of annual dementia training.</p> <p>3.1-14(u)</p>		<p>with required training weekly for a minimum of three months. The Executive Director and/or Designee will perform audits of compliance weekly for a minimum of three months to ensure employee in-servicing compliance. 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>				