

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/11/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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F000000	<p>This visit was for the Investigation of Complaints IN00159537 and IN00159839.</p> <p>Complaint IN00159537 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-223.</p> <p>Complaint IN00159839 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: December 11, 2014</p> <p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Survey team: Julie Baumgartner, RN, TC Shauna Carlson, RN Pam Williams, RN Amy Miller, RN</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Payor type: Medicare: 12 Medicaid: 72 Other: 17 Total: 101</p>	F000000	<p>Preperation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully submit this document as our Plan of Correction for the alleged deficiencies as outline. We respectfully request Desk Compliance</p>	
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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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F000223 SS=A	<p>Sample: 6</p> <p>Golden Living Center-Fountainview was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regard to the Investigation of Complaints IN00159537 and IN00159839. This deficiency reflects state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on December 18, 2014, by Brenda Meredith, R.N.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to prevent an episode of abuse in 1 of 3 incidents of allegations of abuse reviewed. (Resident B)</p>	F000223	It is the intent of Golden Living Fountainview to assure Residents are free from Verbal, Sexual, Physical and Mental Abuse, Corporal Punishment and	01/10/2015			

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	<p>Findings include:</p> <p>On 12-11-2014 at 11:30 A.M., the facility provided a copy of a report of an incident of alleged abuse from 11-7-2014 at 8:15 P.M. The Incident Report that was filed with the Indiana State Department of Health, by the facility, for an incident that occurred on 11-7-2014 at 8:15 P.M. indicated, "...At approximately 8:50 p.m. writer [Executive Director] was notified by [employee name-LPN #5] [Licensed Practical Nurse] of allegation by resident [name-Resident H] of CNA #4 [Certified Nursing Assistant] [employee name] being "mean", "twisting of shoulder of resident", "refusal to give bath to resident" and "failure to ensure dignity of resident allowing resident to "present partially dressed during care" to visiting chaplain. Also at this time writer [Executive Director] was notified of allegation by nurse [employee name, LPN #5] that CNA #4 [employee name] while providing care to resident [name, Resident H] she overheard resident [name, Resident H] yell out "ouch". Nurse [name, LPN #5] stated she entered the room and CNA [employee name, CNA #4] stated "I grabbed her arm" ...Type of Injury added--11-8-2014 Resident [resident name, Resident B] complained of soreness to her left</p>		<p>Involuntary Seclusion at all times. The employee who was alleged to abuse the Resident in the investigation was immediately suspended and later terminated due to the information gathered during the investigation. All Residents have the potential to be affected by this allegation of non-compliance. Residents of the Center were interviewed by the Interdisciplinary Team and no other allegations of abuse or care concerns were identified at the time of the interviews. All allegations of Verbal, Sexual, Physical and Mental Abuse, Corporal Punishment and Involuntary Seclusion will be investigated and reported timely to the Administrator (or their delegated coverage) the Family and Physician of the Resident, and Governing bodies as per policy and ISDH guidelines. Residents will be observed during daily rounding by the Interdisciplinary Team for signs/symptoms of the above allegation. Staff will be re-educated at each instance of suspicion of Verbal, Sexual, Physical and Mental Abuse, Corporal Punishment and Involuntary Seclusion. In the event an allegations as outlined above, the staff member will be immediately removed from care and suspended pending outcome of investigation into the allegation. Allegations of above will be reported and recorded</p>				

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	<p>shoulder at time of incident Resident [resident name, Resident H] expressed complaints of soreness to left arm at time of incident...Immediate Action Taken...Action Taken added--11-8-2014 CNA [employee name, CNA #4] was dismissed from her shift immediately after incident. She was escorted from the center by charge nurse [employee name, LPN #5]. Resident(s) family and physician assigned notified. Social Services notified. Hospice notified of resident [resident name, Resident B] incident. Nurse [employee name, LPN #5] and Chaplin [name] with Hospice offered support to resident [resident name, Resident B] and resident [resident name, Resident H]. Abuse, Neglect, and Resident Rights re-education to staff began immediately. Frequent checks were implemented to both residents to assure comfort, free from pain and fear. X-ray was ordered to rule out any unseen injury...Preventive Measures Taken...Type of preventative measures added--11-8-2014 CNA [employee name, CNA #4] has been suspended pending investigation. Adult Protective Services, Ombudsman, and local law enforcement to be notified of incident allegation(s). staff will be re-educated related to Resident Rights, Abuse, and Neglect. Staff will be re-educated to transfer technique and use of gait belt</p>		<p>timely in the Reportable log maintained by the Administrator and the Director of Nursing Services. This log will be reviewed at each Quality Assurance Performance Improvement (QAPI) meeting by the Interdisciplinary Team, and the Medical Director for trends and any further education needed. This review will continue indefinitely. These changes will be completed on or before January 10, 2015.</p>				

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	<p>related to resident safety and comfort. Staff re-educated to use of Resident Care Guide. Staff were re-educated to address any spills or concerns to resident and staff safety...Follow up:....11/17/14 following investigation into the allegations it was noted:...-CNA [employee name, CNA #4] did not follow the Resident Care Guide for the care of Resident [resident names, Resident B and Resident H]. CNA [employee name, CNA #4] did not use her assigned gait Belt during resident(s) transfer. CNA[employee name, CNA #4] did not announce self before entering resident room by knocking or verbalization. CNA [employee name, CNA #4] began providing care without introduction or explanation. CNA [employee name, CNA #4] did not provide privacy for resident [resident name, Resident B] during PM care. CNA [employee name, CNA #4] failed to clean up spilled water when asked by resident [resident name, Resident B]...-CNA [employee name, CNA #4] was discharged from employment on 11/10/14...."</p> <p>On 12-11-2014 at 11:35 A.M., record review of the policy "Reporting Alleged Violation" received by Social Services on 12-11-14 at 10:30 A.M. The policy indicated, "...Policy...It is the policy of this center to take appropriate steps to</p>						

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	<p>prevent the occurrence of: abuse...Staff and volunteer training...Upon hire, each new employee is informed of the obligation to report alleged violations...Training also include examples of reportable incidents to assist staff in detection of such incidents...Each employee receives training no less frequently than annually...."</p> <p>On 12-11-2014 at 1:45 P.M., an interview with LPN #6 was conducted related to abuse. LPN #6 indicated, "...we are in-serviced monthly on abuse and after every incident or allegation...."</p> <p>On 12-11-2014 at 1:50 P.M., an interview with LPN #7 was conducted related to abuse. LPN #7 indicated, "...we have in-services every month on abuse and after every incident...it [abuse] is taken very seriously and we have a no tolerance policy...."</p> <p>On 12-11-2014 at 4 P.M., during an interview, the Executive Director indicated that CNA #4 was terminated and the incident had been reported to the licensure board.</p> <p>This Federal tag relates to Complaint IN00159537.</p> <p>3.1-27(a)(1)</p>						

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