

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
-----------------------------------------------------------------------------	------------------------------------------------------------------------------

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

F000000	<p>This visit was for the Investigation of Complaint IN00139619.</p> <p>Complaint IN00139619-Substantiated. Federal/State deficiencies related to the allegation are cited at F157 and F204.</p> <p>Survey date: November 12, 2013</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF/NF: 160 Total: 160</p> <p>Census payor type: Medicare: 24 Medicaid: 123 Other: 13 Total: 160</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000		
---------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	--	--

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
-----------------------------------------------------	--------------------------------------------------------------------	--------------------------------------------------------------	--------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
-----------------------------------------------------------------------------	------------------------------------------------------------------------------

(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
	Quality review completed on November 17, 2013, by Janelyn Kulik, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
-----------------------------------------------------------------------------	------------------------------------------------------------------------------

(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
F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the resident's Physician of information received from another Agency related to guardianship and competency for 1</p>	F000157	F 157 Step 1- Resident discharged on November 7th, 2013. Step 2 - Residents that will be discharged from facility have the potential to be affected. Audit was completed to identify	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368			
(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>of 3 resident's reviewed for discharge to their residences in the sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 11/12/13 at 9:45 a.m. The resident was admitted to the facility from the hospital on 10/4/13. The resident was discharged to his home residence on 11/7/13. The resident signed the facility Admission agreement on 10/4/13. The resident signed his Discharge Summary sheet indicating post discharge care needs were reviewed with the resident on 11/7/13. The resident did not reside on the dementia unit.</p> <p>The resident's diagnoses included, but were not limited to, high blood pressure, chronic pain, congestive heart failure, neurogenic bladder, anxiety state, urinary tract infection, and depressive disorder. Review of the 10/1/13 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (10). This score indicated the resident's cognitive patterns were moderately impaired. The assessment indicated the resident displayed no behaviors.</p>		<p>residents due to discharge for any unsafe discharge potential. No other residents were identified. Step 3 - Residents discharging will be reviewed for any potential barriers to discharge. If any indicators of an unsafe discharge are identified the facility will notify the Physician and APS as appropriate before discharging the resident from the facility. Discharges will be reviewed in Clinical Startup meeting by IDT. Re-education and In-servicing of staff involved with discharge planning. This will include Nursing staff, Therapy, and Social Services. The DNS/Designee will audit discharges to ensure safe discharge planning took place and that Physician was notified of any unsafe discharge potential. Audits will be completed 5 times a week for 8 weeks, then 3 times a week for 8 weeks, then 2 times a week for 4 weeks, then weekly times 4 weeks. Step 4 - The results of the discharge audits will be discussed during the Clinical Start up meeting weekly and will be ongoing. Audits will be discussed in Monthly QAPI for review for six months. If after six months without any identified issues the results will be reviewed quarterly by the QAPI Committee. Completion Date: December 1st, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
-----------------------------------------------------------------------------	------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The Mood assessment on the MDS indicated the resident had trouble falling asleep and had a poor appetite with no other symptoms of mood disorders. The assessment also indicated the resident had an indwelling Foley catheter in place, required limited assistance (resident highly involved in activity) for transfers and dressing. The MDS assessment indicated the resident's goals were to return to the community and active discharge plans were in place.</p> <p>A Physician order was obtained on 11/5/13 at 4:20 p.m. to discharge the resident home. The order indicated the resident was to be discharged home with Home Health services, Physical Therapy, and Occupational Therapy on 11/7/13.</p> <p>The Physician Progress Notes were reviewed. A Progress Note completed on 10/7/13 indicated the resident was a "well known patient of ours" and was recently hospitalized for a UTI (Urinary tract infection) and hematuria(blood in the urine). The note also indicated the resident was unable to ambulate in the hospital and was transferred to the facility for rehabilitation. The 11/4/13 Physician Progress Note indicated the resident was doing well and alert and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368		
(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>orientated.</p> <p>Review of the 10/2013 and 11/2013 Progress Notes indicated an entry was made by Nursing on 10/27/13 at 9:03 a.m. This entry indicated the resident was alert and orientated x 3 (orientated to person, place, & time). An entry made by the Alzheimer Care Director on 11/5/13 at 8:30 a.m. indicated she spoke with the resident regarding his last day of therapy being 11/6/13 and his discharge to be on 11/7/13. The resident indicated he had no preference for choice of Home Health services upon discharge.</p> <p>An entry made was made on 11/5/13 at 2:40 p.m. This entry was made by Alzheimer Care Director. The entry indicated a meeting was held with the resident to discuss his discharge home on 11/7/13. The resident indicated he was agreeable to Home Health, Physical and Occupational Therapy services upon discharge. The entry also noted the resident indicated he had no one in the area to assist him. The entry also indicated a message was left with the Physician to update him.</p> <p>An entry made by the Alzheimer Director on 11/5/13 at 3:45 p.m. indicated APS (Adult Protective</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368		
(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>Services) was notified and information was provided.</p> <p>A Nursing Progress Note was made on 11/5/13 at 4:18 p.m. This entry indicated an order was received from the Physician for Home Health, Physical Therapy and Occupational Therapy for the resident's discharge. The entry also indicated (name of a local Pharmacy) was to be called with the resident's medications.</p> <p>An entry was made by the Alzheimer Care Director on 11/6/13 at 1:21 p.m. This entry indicated a phone call was received from an APS staff member related to the resident. The entry noted APS indicated the resident was in their system and they had a previous report dated 1/25/13 stating the resident was unable to manage his affairs and this was referred to the Guardianship agency at the time though they had not yet obtained the Guardianship. The entry also indicated a call was made to the Guardianship agency and a message was left for them to call the facility. The Alzheimer Director indicated APS then faxed the information to the facility.</p> <p>Another entry was made by the Alzheimer Care Director on 11/6/13 at</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368			
(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>4:13 p.m. This entry indicated a representative from the Guardianship Agency called the facility. The representative indicated a pro-bono attorney was called and could go in front of a Judge for guardianship. This entry indicated the Director spoke with the resident and indicated he was going home as arrangements were already made.</p> <p>An entry dated 11/7/13 at 3:33 p.m. indicated the resident was discharged home at approximately 3:10 p.m. The resident was in good condition and denied pain or discomfort at the time and he was educated on continued care. This entry was completed by Nursing staff.</p> <p>The only Progress Notes made between 11/5/13 and 11/7/13 were completed by Nursing staff or the Alzheimer Care Director. There was no documentation of the resident's Physician being notified of the above contact with and/or the information received from the APS and Guardianship Agencies.</p> <p>When interviewed on 11/12/13 at 11:20 a.m., the Alzheimer Care Director indicated she was involved in the discharge planning for Resident #B. The Director indicated the facility</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
-----------------------------------------------------------------------------	------------------------------------------------------------------------------

(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>had a Medicare meeting to review the resident's discharge plans and the team had concerns related to resident being discharged home alone. The Director indicated the only contact listed on the resident's admission information was a neighbor. The Director indicated the resident signed all his admission paperwork himself. The Director spoke with the neighbor who indicated the resident had Home Health in the past at times would not let them in his home. The neighbor indicated the resident had a Niece but was estranged from her now. The Director indicated the neighbor gave her the Niece's phone number and she attempted to call the Niece who stated she was not going to be involved in the resident's care.</p> <p>The Director also indicated when they contacted APS to explain the above APS then preceded to tell her about the 1/2013 process of attempting to obtain guardianship and the guardianship case had not ever been completed as of this date. The Director indicated APS suggested they keep the resident against his will.</p> <p>The Director also indicated she contacted the Guardianship Agency and they indicated they could try and find a pro-bono Lawyer to take the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
-----------------------------------------------------------------------------	------------------------------------------------------------------------------

(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>case to a Judge. The Director indicated she was informed they could set up a case with the Judge for "tomorrow." The Director indicated she informed the facility Administrator of the above phone calls at the time.</p> <p>The Director indicated she spoke with Resident #B and asked him to stay another day and he was angry and argumentative about wanting to be discharged. The Director indicated she also phoned the resident's Physician's office and left a message for the Physician to call her back related to above information obtained per the conversations with APS and the Guardianship Agencies. The Director indicated she did not receive a return call from the Physician to confirm the Physician received her message and she did not inform the facility Administrator of her phone call to attempt to notify the Physician.</p> <p>The Director also indicated she made the arrangement for the resident to receive Home Health Services and did not inform them of the Guardianship concerns when she made the arrangement for the resident to be discharged home. The Director indicated the resident was alert and orientated x 3 and had some impaired decision making and she did</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368			
(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>not feel he would harm himself.</p> <p>When interviewed on 11/12/13 at 12:35 p.m., the facility Administrator indicated a day or two before Resident #B's discharge the Business Office indicated the resident's managed care provider cut off payment for the resident and discharge plans were made. The Administrator indicated when the resident was admitted the plan of care was for the resident to return home. The Administrator indicated he was informed by the Alzheimer Care Director about the phone calls from APS and the Guardianship agency. The Administrator indicated the Physician had given the order for the resident to be discharged home. The Administrator indicated he had not spoken with the Physician. The Administrator indicated he was not aware the resident's Physician had not been informed of the above contacts with APS and the Guardianship Agencies.</p> <p>When interviewed on 11/12/13 at 2:10 p.m., the Director of Nursing indicated the Physician should have been informed of the contacts and calls with APS which occurred after the Physician orders were first received. The Director of Nursing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
-----------------------------------------------------------------------------	------------------------------------------------------------------------------

(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>indicated the Physician's order for the resident to be discharged was obtained on 11/5/13 and the resident was discharged on 11/7/13.</p> <p>The facility policy titled "Notification of Change in Resident Health Status" was reviewed. There was no date on the policy. The Director of Nursing provided the policy and identified the guidelines as current standards. The policy indicated the resident's Physician was to be notified of the need to alter treatment or any significant change in the resident's physical, mental, or psychosocial status.</p> <p>This federal tag relates to Complaint IN00139619.</p> <p>3.1-5(a)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368		
(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	
F000204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>Based on record review and interview, the facility failed to ensure the Home Health Service arranged to provided post discharge care was notified of information obtained from APS (Adult Protective Services) and another Guardianship Agency prior to discharge for 1 of 3 residents discharged to their residences in the sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 11/12/13 at 9:45 a.m. The resident was admitted to the facility from the hospital on 10/4/13. The resident was discharged to his home residence on 11/7/13. The resident signed the</p>	F000204	<p>F204 Step 1 -Resident discharged on November 7th, 2013. Step 2 - Residents that will be discharged from facility have the potential to be affected. Audit was completed to identify residents due to discharge for any unsafe discharge potential. No other residents were identified.</p> <p>Step 3- Residents discharging will be reviewed for any potential barriers to discharge. If any indicators of an unsafe discharge are identified the facility will notify the Physician, APS and the Home Health Agency as appropriate before discharging the resident from the facility. Discharges will be reviewed in Clinical Startup meeting by IDT. Re-educate and In-service staff involved with discharge planning. This will include Nursing staff, Therapy,</p>	12/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368		
(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>facility Admission agreement on 10/4/13. The resident signed his Discharge Summary sheet indicating post discharge care needs were reviewed with the resident on 11/7/13.</p> <p>A Physician order was obtained on 11/5/13 at 4:20 p.m. to discharge the resident home. The order indicated the resident was to be discharged home with Home Health services, Physical Therapy and Occupational Therapy on 11/7/13.</p> <p>A Nursing Progress Note was made on 11/5/13 at 4:18 p.m. This entry indicated an order was received from the Physician for Home Health, Physical Therapy and Occupational Therapy for the resident's discharge. The entry also indicated (name of a local Pharmacy) was to be called with the resident's medications.</p> <p>An entry was made by the Alzheimer Care Director on 11/6/13 at 1:21 p.m. This entry indicated a phone call was received from an APS staff member related to the resident. The entry noted APS indicated the resident was in their system and they had a previous report date 1/25/13 stating the resident was unable to manage his affairs and this was referred to the Guardianship agency at the time</p>		<p>and Social Services. The DNS/Designee will audit discharges to ensure safe discharge planning is in place and that the Home Health Agency was notified of unsafe discharge potential and given a full report on what the needs are of the resident. Audits will be completed 5 times a week for 8 weeks, then 3 times a week for 8 weeks, then 2 times a week for 4 weeks, then weekly times 4 weeks. Step 4- The results of the discharge audits will be discussed during the Clinical Start up meeting weekly and will be ongoing. Audits will be discussed in Monthly QAPI for review for six months. If after six months without any identified issues the results will be reviewed quarterly by the QAPI Committee. Completion Date: December 1st, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368			
(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>though they had not yet obtained the Guardianship. The entry also indicated a call was made to the Guardianship agency and a message was left for them to call the facility. The Alzheimer Director indicated APS then faxed the information to the facility.</p> <p>Review of the 10/2013 and 11/2013 Progress Notes indicated an entry was made by Nursing on 10/27/13 at 9:03 a.m. This entry indicated the resident was alert and orientated x 3 (orientated to person, place, & time). An entry made by the Alzheimer Care Director on 11/5/13 at 8:30 a.m. indicated she spoke with the resident regarding his last day of therapy being 11/6/13 and his discharge to be on 11/7/13. The resident indicated he had no preference for choice of Home Health services upon discharge.</p> <p>An entry made was made on 11/5/13 at 2:40 p.m. This entry was made by Alzheimer Care Director. The entry indicated a meeting was held with the resident to discuss his discharge home on 11/7/13. The resident stated he was agreeable to Home Health, Physical and Occupational services upon discharge. The entry also noted the resident indicated he had no one in the area to assist him.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The entry also indicated a message was left with the Physician to update him.</p> <p>An entry made by the Alzheimer Director on 11/5/13 at 3:45 p.m. indicated APS (Adult Protective Services) was notified and information was provided.</p> <p>An entry dated 11/7/13 at 3:33 p.m. indicated the resident was discharged home at approximately 3:10 p.m. The resident was in good condition and denied pain or discomfort at the time and he was educated on continued care. This entry was completed by Nursing staff.</p> <p>The only Progress Notes made between 11/5/13 and 11/7/13 were completed by Nursing staff or the Alzheimer Care Director. There was no documentation of the Home Health Service provider being notified of the above contact with and/or the information received from the APS and Guardianship Agencies.</p> <p>When interviewed on 11/12/13 at 2:10 p.m., the Director of Nursing indicated the Physician should have been informed of the contacts and calls with APS which occurred after the Physician orders were first</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368		
(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>received. The Director of Nursing indicated the Physician's order for the resident to be discharged was obtained on 11/5/13 and the resident was discharged on 11/7/13. The Director of Nursing also indicated the Home Health provider should have been notified of the above also as the facility was aware the resident had no family or friend living with him upon discharge.</p> <p>This federal tag relates to Complaint IN00139619.</p> <p>3.1-12(a)(21)</p>				