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 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	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	This visit was for the Investigation of Complaint IN00157218. This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaints IN00155592, IN00155844, IN00153982 and IN00153717 completed on 9/22/14. Complaint IN00157218-Substantiated. Federal/State deficiency related to the allegations is cited at F371. Unrelated deficiencies are cited. Survey dates: November 5 and 6, 2014. Facility number: 000098 Provider number: 155187 AIM number: 100290980 Survey team: Yolanda Love, RN-TC Lara Richards, RN Heather Tuttle, RN Census bed type: SNF/NF: 154 Total: 154	F000000	This Plan Of Correction constitutes the facility's written allegation of compliance for the deficit sited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. The facility, Golden Living Center - Fountainview Place, respectfully requests consideration of this Plan of Correction to be granted paper compliance.	

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

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

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	Census payor type: Medicare: 22 Medicaid: 122 Other: 10 Total: 154 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 10, 2014, by Janelyn Kulik, RN.			
F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.			

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	The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure the Administrator and the State Agency were promptly notified of an allegation of physical abuse between two residents for 1 of 3 allegations of physical abuse reviewed between residents. (Residents #B and #D Findings include: The record for Resident #B was reviewed on 11/5/14 at 1:50 p.m. The resident's	F000225	**F 225** **Investigate/Report/Allegations** **The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice:** Reported to ISDH 11-14-14. On Call Nurse educated to call DNS and Administrator for allegations of abuse. DNS educated to report all allegations of abuse. **How other Residents having the potential to be affected by**	11/28/2014

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	diagnoses included, but were not limited to, dementia without behavioral disturbance. Review of Nursing progress notes dated 10/20/14 at 12:15 a.m., indicated the resident came out into hall and said that his roommate (Resident #D) got into the bed with him, bit his hand and twisted his arm. Upon assessment of the resident there were no bite marks or injuries noted to his hand. No redness or bruising noted at this time. Will continue to monitor throughout this shift. At that time, the on call nurse was notified, and aware of both patients having dementia. The next documented entry in Nursing progress notes was dated 10/20/14 at 2:40 p.m., indicating the Physician was notified of the resident's lab results. Interview with LPN #1 on 11/06/14 at 11:29 a.m., per a telephone conversation, indicated when Resident #B came out of the room and said his roommate had bit him and twisted his arm, she immediately removed the resident from the room. She called the on call supervisor who told her to go and assess Resident #B and offer to move him to another room. The LPN indicated she had done that, however, the resident did not want to go into any room.		**the same alleged deficient practice were identified and corrective action was taken:** Any resident who is involved in a physical altercation has the potential to be affected by the alleged deficient practice. Staff educated to report any physical altercations to DNS and Administrator immediately. **Measures that were put in place or what systemic change to ensure that the deficient practice does not recur:** Staff to be educated by 11-24-14 HR-408 Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property and also on Indiana State Department of Health -Reportable Incidents Policy. **How the corrective action will be monitored to ensure the deficient practice does not recur:** Audit created - Exhibit A: Audit to be completed by DNS or designee daily x 4 weeks, weekly x 3 months, 2 x a month x 2 months, monthly x 1 months. **Compliance to be monitored by QAPI for trends/patterns until compliance is achieved.** **Date the systemic changes will be completed 11-28-14.**	

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	Interview with the B Wing Unit Manager on 11/06/14, at 11:03 a.m., indicated she was the on call supervisor for 10/20/14. She indicated LPN #1 called and informed her of the incident with Resident #B and #D. She instructed the LPN to move the resident to a different room. The B Wing Unit Manager indicated she did not immediately notify the Director of Nursing (DoN) or the Administrator at that time, because she did not think of the incident as being an allegation of physical abuse between two residents. She thought of it as two residents with dementia due to there was no physical evidence of harm on Resident #B. She indicated when she came to work the next day, she had brought the incident up at the stand up morning meeting. Interview with the DoN on 11/6/14 at 10:50 a.m., indicated she was made aware of the situation in the morning during the stand up meeting. She further indicated she does not know why she did not report the issue to the State Agency. Interview with the Administrator on 11/6/14 at 1:53 p.m., indicated he was first made aware of the allegation of physical abuse between Resident #B and Resident #D regarding the biting and			

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	twisting of Resident B's arm today. He further indicated he was not immediately notified of the incident nor did he notify the State Agency. 3.1-28(c)			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their abuse policy related to ensuring the Administrator and the State Agency were promptly notified of an allegation of physical abuse between two residents for 1 of 3 allegations of physical abuse reviewed between residents. (Residents #B and #D) Findings include: The record for Resident #B was reviewed on 11/5/14 at 1:50 p.m. The resident's	F000226	**F 226 Development/Implement Abuse/Neglect Policies** **The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice:** Reported to ISDH 11-14-14. On Call Nurse educated to call DNS and Administrator for allegations of abuse. DNS educated to report all allegations of abuse. **How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken:**	11/28/2014

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	diagnoses included, but were not limited to, dementia without behavioral disturbance. Review of Nursing progress notes dated 10/20/14 at 12:15 a.m., indicated the resident came out into hall and said that his roommate (Resident #D) got into the bed with him, bit his hand and twisted his arm. Upon assessment of the resident there were no bite marks or injuries noted to his hand. No redness or bruising noted at this time. Will continue to monitor throughout this shift. At that time, the on call nurse was notified, and aware of both patients having dementia. The next documented entry in Nursing progress notes was dated 10/20/14 at 2:40 p.m., indicating the Physician was notified of the resident's lab results. Interview with LPN #1 on 11/06/14 at 11:29 a.m., per a telephone conversation indicated when Resident #B came out of the room and said his roommate had bit him and twisted his arm, she immediately removed the resident from the room. She called the on call supervisor who told her to go and assess Resident #B and offer to move him to another room. The LPN indicated she had done that, however, the resident did not want to go into any room.		Any resident who is involved in a physical altercation has the potential to be affected by the alleged deficient practice. Staff educated to report any physical altercation toDNS and Administrator immediately. **Measures that were put in place or what systemic change to ensure that the deficient practice does not recur:** Staff to be educated by 11-24-14 HR-408 Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property and also on Indiana State Department of Health -Reportable Incidents Policy. Audit created. **How the corrective action will be monitored to ensure the deficient practice does not recur:** Audit created - Exhibit A: Audit to be completed by DNS or designee daily x 4 weeks, weekly x 3 months, 2 x a month x 2 months, monthly x 1 months. **Compliance to be monitored by QAPI for trends/patterns until compliance is achieved.** **Date the systemic changes will be completed 11-28-14.**	

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	twisting of Resident B's arm today. He further indicated he was not immediately notified of the incident nor did he notify the State Agency. Review of the 10/24/13 and current Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property policy provided by the DoN indicated "It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injures of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violations"), are reported immediately to the Executive Director of the center/location.... Such violations will also be reported to state agencies in accordance with existing law." 3.1-28(a)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT			

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	HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident was monitored closely after an alleged altercation of physical abuse between a resident which led to another altercation of another resident which resulted in that resident being hospitalized with a laceration to the head as well as a c-spine fracture to the neck for 1 of 3 allegations of physical abuse between residents reviewed. (Residents #B, #C and #D) Findings include: The record for Resident #B was reviewed on 11/5/14 at 1:50 p.m. The resident's diagnoses included, but were not limited to, dementia without behavioral disturbance. Review of the Annual Minimum Data Set (MDS) assessment dated 8/4/14 indicated the resident's Brief Interview for Mental Status (BIMS) was a 4 indicating he was not alert and oriented. The resident was identified as having no behavior or mood problems. Review of Nursing progress notes dated	F000323	**F 323 Free of Accident Hazards/Supervision/Devices** **The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice:** Unable to correct the alleged deficient practice. **How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken:** Any resident who is near another resident who is actively under close visual observation or on 1:1 supervision has the potential to be affected by the alleged deficient practice. - **Measures that were put in place or what systemic change to ensure that the deficient practice does not recur:** Staff to be educated by 11-24-14. Adequate supervision, type and frequency of supervision, based on the individual resident's assessed needs and identified hazards to themselves or others.	11/28/2014

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	10/20/14 at 12:15 a.m., indicated the resident came out into hall and said that his roommate (Resident #D) got into the bed with him, bit his hand and twisted his arm. Upon assessment of the resident there were no bite marks or injuries noted to his hand. No redness or bruising noted at this time. Will continue to monitor throughout this shift. At that time, the on call nurse was notified, and aware of both patients having dementia. The next documented entry in Nursing progress notes was dated 10/20/14 at 2:40 p.m., indicating the Physician was notified of the resident's lab results. Review of Resident #Ds record on 11/5/14 at 2:30 p.m. indicated his diagnoses included but were not limited to, delirium, presenile dementia with delirium, and psychosis. The resident was admitted to the facility on 10/13/14. Review of Nursing progress notes dated 10/20/14 at 4:47 a.m., indicated "Resident up during the night turning over tables, stripping, becomes easily agitated and combative with redirection toward staff. Yells out in intermittent intervals during the night." Continued review of Nursing progress notes dated 10/20/14 at 6:30 p.m.,		**How the corrective action will be monitored to ensure the deficient practice does not recur:** Audit created - Exhibit A: Audit to be completed by DNS or designee daily x 4 weeks, weekly x 3 months, 2 x a month x 2 months, monthly x 1 months. **Compliance to be monitored by QAPI for trends/patterns until compliance is achieved.** **Date the systemic changes will be completed 11-28-14.**	

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	indicated the resident was seen walking into Resident #C's room and sat on the bed. Resident #C told Resident #D that he was in the wrong room and to get off the bed before he called the police. Resident #D stood up and shoved Resident #C. Further review of Nursing progress notes indicated after the incident the resident was observed wandering in and out of rooms his gait was unstable at times and the resident became very verbally and physically aggressive with redirection. One to one supervision was maintained. The resident's Physician was notified and orders received to send to the hospital. Continued review of Resident #D's record indicated a behavior monitoring log sheet had been completed on 10/20/14 which indicated "Describe behavior: disrobing turning over tables over-physical aggression yelling out wandering shoved other resident refusing meds." Review of a current plan of care dated 10/2014 indicated "I sometimes have behaviors which include physical aggression, disrobing, exposing self, wandering and exit seeking and refusing care." The Nursing approaches were "help me avoid situations or people that are upsetting to me. Make sure I am not			

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	in pain. Please tell me what you are going to do before you begin. Speak to me unhurriedly and in a calm voice." Continued review of Nurse's notes dated 10/20/14 indicated the resident returned from the hospital at 11:00 p.m. Review of Physician Orders dated 10/21/14 indicated "1 to 1 supervision every shift for behaviors. Further review of Physician Orders dated 10/23/14 indicated the resident was discharged to a psychiatric hospital for evaluation. Review of Resident #C's record on 11/5/14 at 2:45 a.m., indicated a Nurse's note dated 10/20/14 at 6:30 p.m., that indicated resident saw Resident #D walk into his room and sit on his bed. Resident #C told him to leave and Resident #D stood up and shoved him, knocking him to the floor near the second bed in the room. Resident #C sustained a 3 centimeter (cm) by 3 cm laceration to the back of his upper left head with active bleeding. Resident #C had complaints of a headache and dizziness. The Physician was notified and an order was obtained to send to the hospital. Resident #C was admitted to the hospital at that time with a fracture of the C-2 spine and a laceration to the head.			

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	Interview with LPN #2 on 11/6/14 at 8:25 a.m., indicated she works full time during day shift. LPN #2 recalled coming into work the morning of 10/20/14. She indicated she was told in report that Resident #B came out into the hall that night and stated Resident #D bit him and twisted his arm. She further indicated the midnight nurse had called the on call nurse and moved the resident out of the room for the evening. Continued interview with LPN #2 indicated Resident #D was observed in Resident #C's room. Resident #D sat on his bed, and Resident #C told him to get up or he was going to call the police. She further indicated Resident #D got up and shoved Resident #C knocking him to the ground. She indicated they immediately started 1 to 1 supervision with Resident #D, however, prior to the incident he had not been on 15 minute checks or 1 to 1 supervision. Further interview indicated Resident #D was placed on 1 to 1 supervision with an actual person who stayed with him at all times after he returned from the hospital. Interview with LPN #1 on 11/06/14 at 11:29 a.m., per a telephone conversation indicated when Resident #B came out of the room and said his roommate had bit him and twisted his arm, she immediately removed the resident from the room. She			

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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
	called the on call supervisor who told her to go and assess Resident #B and offer to move him to another room. The LPN further indicated she had not placed Resident #D on 15 minute checks or 1 to 1 direct staff supervision. She indicated they monitored both residents during the night. 3.1-45(a)(2)			
F000371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions related to transporting lunch trays with uncovered food from the Main Kitchen to Unit C. (Unit C) Findings include: On 11/06/2014 at 1:10 p.m., lunch trays were observed being transported from the Main Kitchen to Unit C, the deserts placed on the trays were observed to be	F000371	**F 371 Food Procure/Store/Prepare The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice:** Unable to correct the alleged deficient practice for Unit-C. **How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action was taken:** Any resident who has their meal transported from the Main Kitchen to their unit has the potential to be affected by the	11/28/2014

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	uncovered. There was construction work going on in the hallways leading from the kitchen to the unit. There was also construction work being performed on Unit C at the time of the delivery of the lunch trays. On 11/06/2014 2:15 p.m., interview with the Dietary Manager indicated the deserts should have been covered while being transported to the unit. This Federal tag relates to Complaint IN00157218. 3.1-21(i)(3)		alleged deficient practice. Staff educated on covering dessert plates on 11-6-14 for those transported to Unit-C. **Measures that were put in place or what systemic change to ensure that the deficient practice does not recur:** Staff to be educated on Sanitary conditions related to transporting trays from the main kitchen to the different units. Education to be completed by 11-21-14. **How the corrective action will be monitored to ensure the deficient practice does not recur:** Audit created - Exhibit B - Audit to be completed by Dietary Manager or Designee daily, five times a week x 8 weeks, then three times a week for x 8 weeks, then weekly x 2 months, then 2 x a month x 1 months. **Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 11-28-14.**	