

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2011
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN46544
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 17, 18, 19, 20, and 21, 2011</p> <p>Facility number: 000045 Provider number: 155109 AIM number: 100291400</p> <p>Survey team: Vicki Manuwal, RN-TC Sandra Haws, RN- October 17 and 18, 2011 Bobbie Costigan, RN Susan Bruck, RN</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census by payor type: Medicare: 6 Medicaid: 39 Other: 8 Total: 53</p> <p>Samples: 14</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Disclaimer Statement: submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal &amp; 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2011

FORM APPROVED

OMB NO. 0938-0391

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	Quality review completed on October 24, 2011 by Bev Faulkner, RN				

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F0225 SS=D	<p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate alleged physical and sexual abuse and failed to report the abuse to the appropriate state agencies for 1 of 3</p>	F0225	1) Resident #16 was interviewed and no ill effects were observed related to the deficient practice.2) All residents have the potential to be affected. An audit of current residents was completed to	11/07/2011	

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	<p>residents reviewed for abuse in a sample of 14.</p> <p>Resident # 16</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 16, reviewed on 10/19/11 at 11:25 A.M., indicated diagnoses of, but not limited to: malignant neoplasm brain, depressive disorder, anxiety.</p> <p>During initial tour of the facility on 10/17/11 at 2:10 P.M., LPN # 1 indicated Resident # 16 as non interviewable.</p> <p>Review of a Progress Note indicated, "6/7/11...Yesterday (06/06/2011), she claimed that a "200 pound girl was rough with her" when getting her out of bed. At first she stated that she was pulled up by her arms, and then stated that her feet were on the floor "hard." After investigation and speaking with (Resident # 16), the "aide" and (Resident # 16) again, her story changed numerous times throughout the day. Other residents in the area of her room - had no complaints of ANYONE being rough with them. Her hospice nurse also spoke with (Resident # 16) and her story changed yet again. When I spoke with (Resident # 16) later on in the evening (with her boys present) -</p>		<p>ensure that no other residents were affected by this practice. Individual adjustments to care plans were made as appropriate/necessary.3) The facility abuse policy and procedure was reviewed. The Director of Clinical Education and/or Designee will in-service management staff by 11/07/11 related to allegations of abuse and following facility policy and procedure with any allegation of abuse to prevent potential further abuse while the investigation is in process. The DQI investigation process will be utilized for all allegations of abuse to ensure a thorough and complete investigation is performed. The DCE and/or Designee has in-serviced staff on recognizing and reporting all allegations of abuse.4) The DNS and/or Designee and the Social Services Director will audit progress notes and 24 hour report sheets to ensure allegations of abuse are followed up on 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 six months and will continue until no further issues are noted. Issues noted will be reported to the IDT team in morning meeting for review and corrective action as needed.5) Any concerns will be monitored through the QAA process for a minimum of 6 months.</p>	

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	<p>she stated that "it happens to everyone!" I asked her what does, and she stated that "200 pound person." She could not tell me if the person was black or white or when it happened...(Name) Social Services..."</p> <p>Review of a second Progress Note indicated, "7/4/11...Behaviors/delusions: Resident speaking of delusional thoughts this shift. Stated to this nurse and CNA "there was a wild party here last night and some man came in my room to have sex with me, it was wild"....(Name) LPN # 1..."</p> <p>Review of Resident # 16's "Significant Change MDS (Minimum Data Set)", dated 6/25/11, indicated a cognition level of "7" indicative of severe cognitive impairment.</p> <p>The complete investigations related to the 6/6/11 incident and 7/4/11 incident were requested on 10/19/11 at 3:30 P.M., from the DON (Director of Nursing).</p> <p>Review of the facility's staffing schedules for 7/3/11, indicated a male CNA (Certified Nurses Aide) was scheduled from 2:00 P.M. to 10:00 P.M.. On 7/4/11, no male staff members were scheduled to work.</p>			

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	<p>Review of a non dated, handwritten statement received on 10/19/11 at 4:45 P.M., indicated, "... (Resident # 16)...re (regarding) statement made on 7/4/11. Reviewed resident's allegation of a man coming in her room to have sex with her. There were no male staff members working on that night, nor were any male visitors noted in or near (Resident # 16) room, per discussion with staff. (Name)" This hand written statement was signed by LPN # 1.</p> <p>Review of a statement, dated 10/20/11, received on 10/21/11 at 10:40 A.M., from the hospice nurse, indicated, "...On 6/6/2011 I visited the patient in question, (Name) for a routine nursing visit. During our conversation (Resident # 16) stated to me that a large woman who was a nursing aid (sic) had been rough with her. (Resident # 16) was unable to provide any further details or answer any specific questions regarding the incident....Both I and the social worker discussed this statement privately with the patient. When asked about who was rough with her, (Resident # 16) was unable to provide a name of the aide, what shift she worked, what she looked like and when and where the incident had taken place. The aides working were unaware of this incident and (Resident # 16) had not made the same complaint to</p>				

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	<p>them. The nurses working that afternoon were also unaware of any incident or statement made by (Resident # 16)."</p> <p>Interview with the DON on 10/19/11 at 4:00 P.M., she indicated there is not an investigation on paper or a reportable related to the 7/4/11 allegation. She further indicated the nurses working did an investigation because they looked to see if there were any male staff members on duty during the night. She also indicated Resident # 16's history is such that she makes inappropriate comments.</p> <p>During interview on 10/19/11 at 4:00 P.M., the Social Service Director indicated herself and the hospice nurse worked together in regards to the 6/6/11 incident. She further indicated Resident # 16 kept changing her story. She also indicated she checked the schedule to see if there was a 200 pound person working and there was not. She further indicated her complete investigation was typed in the computer note dated 6/7/11.</p> <p>Interview on 10/19/11 at 4:15 P.M., the Social Service Director indicated she did not hand write anything down as far as what residents she interviewed during the investigation.</p> <p>Review of a non dated, handwritten, non</p>				

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	<p>signed statement, received on 10/20/11 at 9:00 A.M., indicated three resident interviews related to staff treatment of the residents and parties in the facility. All three residents indicated no one has ever been rough with them and they all denied any parties in the facility.</p> <p>During interview with the Social Services Director on 10/20/11 at 10:00 A.M., she indicated she found the above statement from when she interviewed other residents in the facility.</p> <p>Interview on 10/21/11 at 9:15 A.M., the DON indicated neither allegation was reported to the state. She further indicated she has now completed interviews related to the 7/4/11 allegation as she discovered there was actually a party in the facility on 7/3/11.</p> <p>During interview with the DON on 10/21/11 at 10:30 A.M., she indicated the facility does not keep the visitor sign in sheets therefore they are unavailable for review.</p> <p>3.1-28(c)</p>				

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F0226 SS=D	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate and report to the appropriate state agencies all alleged incidents of abuse according to the facility policies and procedures. This affected 1 of 3 residents reviewed for allegations of abuse in the sample of 14.</p> <p>Resident # 16</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 16, reviewed on 10/19/11 at 11:25 A.M., indicated diagnoses of, but not limited to:</p>	F0226	<p>1) Resident #16 was interviewed and no ill effects were observed related to the deficient practice.2) All residents have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Individual adjustments to care plans were made as appropriate/necessary.3) The facility abuse policy and procedure was reviewed. The Director of Clinical Education and/or Designee will in-service management staff by 11/07/11 related to allegations of abuse and following facility policy and procedure with any allegation of abuse to prevent potential further abuse while the investigation is in process. The DQI investigation</p>	11/07/2011

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	<p>malignant neoplasm brain, depressive disorder, anxiety.</p> <p>During initial tour of the facility on 10/17/11 at 2:10 P.M., LPN # 1 indicated Resident # 16 as non interviewable.</p> <p>Review of a Progress Note indicated, "6/7/11...Yesterday (06/06/2011), she claimed that a "200 pound girl was rough with her" when getting her out of bed. At first she stated that she was pulled up by her arms, and then stated that her feet were on the floor "hard." After investigation and speaking with (Resident # 16), the "aide" and (Resident # 16) again, her story changed numerous times throughout the day. Other residents in the area of her room - had no complaints of ANYONE being rough with them. Her hospice nurse also spoke with (Resident # 16) and her story changed yet again. When I spoke with (Resident # 16) later on in the evening (with her boys present) - she stated that "it happens to everyone!" I asked her what does, and she stated that "200 pound person." She could not tell me if the person was black or white or when it happened...(Name) Social Services..."</p> <p>Review of a second Progress Note indicated, "7/4/11...Behaviors/delusions: Resident speaking of delusional thoughts</p>		<p>process will be utilized for all allegations of abuse to ensure a thorough and complete investigation is performed. The DCE and/or Designee has in-serviced staff on recognizing and reporting all allegations of abuse.4) The DNS and/or Designee and the Social Services Director will audit progress notes and 24 hour report sheets to ensure allegations of abuse are followed up on 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 six months and will continue until no further issues are noted. Issues noted will be reported to the IDT team in morning meeting for review and corrective action as needed.5) Any concerns will be monitored through the QAA process for a minimum of 6 months.</p>		

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	<p>this shift. Stated to this nurse and CNA "there was a wild party here last night and some man came in my room to have sex with me, it was wild"....(Name) LPN # 1..."</p> <p>The complete investigations related to the 6/6/11 incident and 7/4/11 incident were requested on 10/19/11 at 3:30 P.M., from the DON (Director of Nursing).</p> <p>Interview with the DON on 10/19/11 at 4:00 P.M., she indicated there is not an investigation on paper or a state reportable related to the 7/4/11 incident.</p> <p>During interview on 10/19/11 at 4:00 P.M., the Social Service Director indicated herself and the hospice nurse worked together in regards to the 6/6/11 incident. She further indicated Resident # 16 kept changing her story. She also indicated she checked the schedule to see if there was a 200 pound person working and there was not. She further indicated her complete investigation was typed in the computer note dated 6/7/11.</p> <p>Interview on 10/19/11 at 4:15 P.M., the Social Service Director indicated she did not hand write anything down as far as what residents she interviewed during the investigation.</p>			

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	<p>Interview on 10/21/11 at 9:15 A.M., the DON indicated neither allegation was reported to the state. She further indicated she has now completed interviews related to the 7/4/11 allegation as she discovered there was actually a party in the facility on 7/3/11.</p> <p>During interview with the DON on 10/21/11 at 10:30 A.M., she indicated the facility does not keep the visitor sign in sheets therefore they are unavailable for review.</p> <p>A facility policy titled "Reporting Alleged Violations," dated March 07, indicated, "...It is the policy of this facility to take appropriate steps to prevent the occurrence of: abuse...It is also the policy of this facility to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ("alleged violations") are reported immediately to the executive director of the facility. Such violations are also reported to state agencies in accordance with existing state law. The facility investigations each such alleged violation thoroughly and reports the results of all investigations to the executive director and his or her designee, as well as to state agencies as required by</p>				

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F0458 SS=E	<p>state and federal law...."</p> <p>3.1-28(a)</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.</p> <p>Based on observation and interview, the facility failed to provide at least 80 square feet per resident in 2) of 31 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).</p> <p>and failed to ensure 100 square feet per resident in 2 of 9 single resident rooms (Rooms 105 and 107).</p> <p>Findings include:</p> <p>1. During the environmental tour on 10/20/2011 at 10:40 a.m., the following multiple rooms were observed to contain less than 80 square feet per resident: The following rooms were certified SNF/NF</p>	F0458	The facility has a waiver on file 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.	11/07/2011

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	<p>for three beds and measured from 70.5 to 72 square feet per resident:</p> <p>*Room 100, 3 beds, 211.5 total square feet. 70.5 square feet per resident.</p> <p>*Room 104, 3 beds, 216 total square feet. 72 square feet per resident.</p> <p>*Room 108, 3 beds, 216 total square feet. 72 square feet per resident.</p> <p>*Room 110, 3 beds, 216 total square feet. 72 square feet per resident.</p> <p>*Room 112, 3 beds, 216 total square feet. 72 square feet per resident.</p> <p>*Room 114, 3 beds, 216 total square feet. 72 square feet per resident.</p> <p>*Room 116, 3 beds 216 total square feet. 72 square feet per resident.</p> <p>*Room 118, 3 beds, 211.5 total square feet. 70.5 square feet per resident.</p> <p>*Room 204, 3 beds, 216 total square feet. 72 square feet per resident.</p> <p>*Room 205, 3 beds, 212.9 total square feet. 71.8 square feet per resident.</p> <p>*Room 206, 3 beds, 215.3 total square</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, IN46544		
(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>feet. 71.8 square feet per resident.</p> <p>*Room 207, 3 beds, 213.6 total square feet. 71.2 square feet per resident.</p> <p>*Room 211, 3 beds, 213.6 total square feet. 71.2 square feet per resident.</p> <p>*Room 213, 3 beds, 213.6 total square feet. 71.2 square feet per resident.</p> <p>*Room 215, 3 beds, 213.6 total square feet. 71.2 square feet per resident.</p> <p>*Room 226, 3 beds, 216 total square feet. 72 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, 2 beds, 141 total square feet. 70.5 square feet per resident.</p> <p>*Room 103, 2 beds, 144 total square feet. 72 square feet per resident.</p> <p>*Room 109, 2 beds, 143 total square feet. 71.5 square feet per resident.</p> <p>*Room 111, 2 beds, 143 total square feet. 71.5 square feet per resident.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/21/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN46544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>3. The following resident rooms were certified SNF/NF for 1 (one) bed and measured less than 100 square feet:</p> <p>*Room 105, 1 bed 91.6 total square feet per resident.</p> <p>*Room 107, 1 bed, 91.6 total square feet per resident.</p> <p>During interview with the Administrator on 10/20/11 at 10:00 A.M., she indicated she is aware of the current room waivers due to the size being less than required square footage per resident. She further indicated she wants to maintain the current room waivers as they are.</p> <p>3.1-19(1)(2)</p>				