STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

(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 IN00158539. Complaint IN00158539 -Substantiated. Deficiency related to the allegations is cited at F 323 Survey date: November 5, 2014 Facility number: 000282 Provider number: 155755 AIM number: 100287520 Survey team: Christine Fodrea, RN, TC Census bed type: SNF: 5 SNF/NF: 104 Total: 109 Census payor type: Medicare: 5 Medicaid: 68 Other: 36 Total: 109 Sample: 3 This deficiency reflects a State finding cited in accordance with 410 IAC 16.2-3.1.	F000000		

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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	Quality review completed on November 7, 2014 by Randy Fry RN.			
F000323 SS=D	483.25(h) FREE OF ACCIDENT 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 interview and record review, the facility failed to use safe transfer techniques when using transfer equipment (a stand up lift) for 1 of 3 residents reviewed for safe transfer equipment use in a sample of 3. (Resident #Q) Findings include: Resident #Q's record was reviewed on 11-5-2014 at 1:25 PM. Resident #Q's diagnose's included but were not limited to depression, anemia, and high blood pressure. A nurse's note dated 10-6-2014 at 8:11 PM indicated Resident #Q required extensive assist of 2 staff for transfers from the wheel chair to bed.	F000323	The submission of this plan of correction does not constitute an admission of agreement of the facts alleged in this statement of deficiencies. The plan is submitted due to requirements under state and federal law. It is the practice of this facility to ensure appropriate treatment and services to maintain or improve the resident's abilities. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Caregiver had already been educated after the incident occurred and retraining was provided prior to the survey. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents receiving transfer assistance have the potential to be affected.	12/05/2014

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	A nurse's note dated 10-8-2014 at 7:58 AM indicated Resident #Q's legs buckled while a CNA was using a stand up lift to transfer the resident from the bed to the wheel chair. The note further indicated Resident #Q received a 3 centimeter (cm) x 2 cm abrasion to the inner side of the right toe. Additionally, the note indicated there were no signs or symptoms of distress. In an interview on 11-5-2014 at 8:45 AM, LPN #1 indicated Resident #Q was interviewable. In an attempted interview on 11-5-2014 at 11:52 AM, Resident #Q was confused, and not making sense in conversation. In an interview on 11-5-2014 at 5:50 AM, CNA #2 indicated she "had picked up a shift" on a unit she did not normally work. She further indicated the nurse had given her proper notice she was to have all 4 of her residents up, washed, and dressed by the time she was to go off shift. CNA #2 further indicated the nurse and CNA#3 had instructed her to ask for help, but when she went to look for the other staff, both indicated they were busy. CNA #2 indicated she made a mistake and attempted to transfer Resident #Q without proper assistance, and when Resident #Q's legs buckled, she got the		In-services will be completed for all nursing staff regarding proper use of standup lift and following assignment sheets. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Audits will be completed by Nursing Management to ensure proper transfers are completed and staff are following assignment sheets. An audit form has been developed for use. 4. How this corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Audits of at least 30 random resident transfers will be completed weekly times four weeks and then monthly times six months with results to QA. QA will review results of the audits, if there have been no incidents reported during the seven month period, the report to QA will be discontinued.	

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	nurse to assist her. CNA #2 indicated she had been reeducated and would now listen to the resident, follow the assignment sheet about resident needs, and not try to do something without proper assistance. In an interview on 11-5-2014 at 6:27 AM, RN #4 indicated all lifts are to be used with 2 persons. This Federal tag relates to Complaint IN00158539. 3.1-45(a)(2)			