

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 01/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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
F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00113583</p> <p>Complaint # IN00113583 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: January 14, 15, 16, 17 & 18, 2013</p> <p>Facility number: 000045 Provider number: 155109 AIM number:100291400</p> <p>Survey team: Debora Kammeyer, RN-TL Shelly Miller-Vice, RN Shauna Carson, RN Lora Swanson, RN</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicare: 5 Medicaid: 38 Other: 10 Total: 53</p> <p>These deficiencies reflect state</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 ourresidents and is submitted solely as a requirement of the provision of Federal &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.

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 01/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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
	findings cited in accordance with 410 IAC 16.2. Quality Review completed on January 28, 2013, by Brenda Meredith, R.N.			

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 01/18/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544		
(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	
F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a care plan for the adverse consequences of psychotropic medications in 1 of 3 residents of 10 reviewed for unnecessary medications. (Resident # 50)</p> <p>Finding includes:</p> <p>The clinical record of Resident # 50 was reviewed on 1-16-13 at 2:45 p.m. The residents diagnoses included, but were not limited to: "...dementia with behavioral disturbances, acute</p>	F0279	F279/D 1) Resident #50 was assessed and no ill effects were observed related to the deficient practice. 2) All residents receiving psychotropic medications have the potential to be affected. An audit of current residents was completed to ensure that no other residents were affected by this practice. Care plans were audited and individual adjustments to care plans were made as appropriate/necessary.3) The facility Behavior Management Guidelines policy was reviewed. The Director of Nursing will in-service licensed nursing staff and SSD regarding care plans	02/08/2013	

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 01/18/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544		
(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>bronchitis, hypertension, edema, chronic kidney disease, altered mental status, anxiety state, and acute kidney failure..."</p> <p>Medication Regimen Review was reviewed on 1-17-13 at 10:15 a.m., and indicated the pharmacist had reviewed the residents medications monthly with no recommendations at that time. A pharmacist review on 11-6-12, indicated Seroquel 15 mg at HS (bedtime) was started on 10-25-12 due to dementia with behavioral disturbances by the family physician at the recommendation of the Nurse Practitioner for a Specialty Medical Group.</p> <p>Record review, on 1/17/13 at 10:32 a.m., indicated there was no Care plan to address which addressed the side effects of psychotropic medications or behaviors.</p> <p>During an interview on 1-17-13 at 10:45 a.m., the Director of Nursing (DON) indicated the Care plan did not have to address psychotropic drug use and their side effects. The DON also indicated the side effects were addressed in the fall risk Care plan. When asked about the side effects being visible on the Medication Administration Record as a reminder</p>		<p>related to potential adverse consequences of psychotropic medications by 02/01/13.4) The DNS and/or Designee will audit the care plans for adverse consequences of psychotropic medications to ensure care plans have been developed for psychotropic medications 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 three months and will continue until no further issues are noted. Issues noted will be reported to the SSD and IDT team in morning meeting for review and corrective action as needed.5) Any concerns will be monitored through QAA process for a minimum of three months.</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 01/18/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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>to assess daily for the side effects of psychotropic drugs the DON indicated the nurses were aware of the side effects. When asked if there was a record of assessment she indicated the nurses would only document a negative response to the psychotropic drug.</p> <p>On 1-17-12 at 11:00 a.m., a policy entitled Behavior Management Guidelines revised on January 2011, indicated a "Licensed nursing staff completes the Plan of Care following identification of antipsychotic medication usage or behavioral concerns."</p> <p>During an interview on 1-18-13 at 10:10 a.m., the Nurse Manager on Unit One indicated the side effects of psychotropic drug use were "suicide, unsteadiness, GI (gastrointestinal) upset, nausea/vomiting, and dizziness."</p> <p>During an interview on 1-18-13 at 10:15 a.m., the Nurse Manager on Unit Two indicated the side effects of psychotropic drug use were: "...diarrhea, nausea/vomiting, seizures and increased restlessness...".</p> <p>3.1-35(a)</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 01/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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

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 01/18/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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			
F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to implement interventions to promote wound healing for 1 of 1 resident reviewed for pressure ulcer prevention. (Resident #17)</p> <p>Findings include:</p> <p>On 1/14/13 at 11:38 a.m., staff interview with Unit Manager (LPN #1) indicated resident #17 currently has a "Stage IV/ Unstageable" pressure ulcer to L (left) heel that was first identified on 12/17/12.</p> <p>On 1/15/13 at 10:00 a.m., record review indicated Resident #17's diagnosis included but was not limited to "...cardiomegaly, ischemic heart disease, cardiovascular accident with left hemaplegia, chronic kidney disease, congestive heart failure,</p>	F0314	<p>F314/D</p> <p>1) Resident #17 no longer resides in the facility.</p> <p>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.</p> <p>3) The facility Skin Integrity Guidelines were reviewed. The Director of Clinical Education and/or Designee will in-service nursing staff by 02/01/13 related to facility skin integrity guidelines.</p> <p>4) The DNS and/or designee will audit residents to ensure interventions to promote wound healing are in place as care planned. Audits will be performed at a minimum of at least five times per week for a minimum of at least three months and will continue until no further issues are noted. Issues noted will be reported to the IDT</p>	02/08/2013			

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 01/18/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544		
(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>atrial fib and anemia...."</p> <p>A Care Plan dated 12/6/12 and updated on 12/17/12, indicated "...Prevelon boot [pressure relieving device] to L heel at all times and to both heels when in bed as ordered...."</p> <p>On 1/16/13 9:49 a.m., Resident #17 was observed resting in bed on his right side, his Prevelon boots were not in place and were not observed in the room. During interview at that time the Director of Nursing (DON) indicated resident #17 should have heel protector boots in place while in bed.</p> <p>3.1-40(a)(1)</p>		<p>team in morning meeting for review and corrective action as needed.</p> <p>5) Any concerns will be monitored through QAA process for a minimum of three months.</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 01/18/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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			
F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observations, record reviews and interviews, the facility failed to provide the actual hours worked on the daily posting of the nursing schedule for the duration of the annual survey, January 14-18,</p>	F0356	F356/C1) All residents have the potential to be affected. An audit of current residents was completed to ensure that no residents were affected by this practice. 2) The facility posted staff nursing information policy	02/08/2013			

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 01/18/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544		
(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>2013.</p> <p>Findings include:</p> <p>1/14/13 at 10:30 a.m., an observation was made of the daily nursing staffing posted on the front hallway. The actual hours worked were not included in the information required by regulations.</p> <p>1/15/13 at 10:30 a.m., an observation was made of the daily nursing staffing posted on the front hallway. The actual hours worked were not included in the information required by regulations.</p> <p>1/16/13 at 10:30 a.m., an observation was made of the daily nursing staffing posted on the front hallway. The actual hours worked were not included in the information required by regulations.</p> <p>1/17/13 at 10:30 a.m., an observation was made of the daily nursing staffing posted on the front hallway. The actual hours worked were not included in the information required by regulation.</p> <p>At 1/17/13 at 2:00 p.m., an interview was conducted with the Medical Records Director. She indicated that</p>		<p>was reviewed and revised as needed. 3) The DNS or designee will in-service the scheduler regarding the revised policy and posting sheet by 02/01/13.4) The DNS and/or designee will audit the facility posted staff nursing information to ensure staffing is posted in a clear and readable format, in a prominent place readily accessible to residents and visitors and that the posting includes the facility name, current date, total and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift and the resident census. Audits will be performed at a minimum of at least five times per week for a minimum of at least one month 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 QAA process for a minimum of one month.</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 01/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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 postings did not include the actual hours worked.</p> <p>At 1/18/13 at 11:45 p.m., an interview was conducted with the Administrator. She indicated the the current form did not include the actual hours worked.</p> <p>13.1-13(a)</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 01/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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
F0458 SS=C	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT 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 22 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). In addition the facility failed to ensure 100 square feet per resident in single resident rooms. (Rooms 105 and 107)</p> <p>Findings include:</p> <p>1. During the environmental tour on 1-16-13 thru 1-17-13, the following multiple rooms were observed to contain less than 80 square feet per resident. The following rooms were certified SNF/NF for three beds and measured from 70.5 to 72 square feet per resident.</p> <p>*Room 100, 2 beds, 211.5 total square feet. 105.75 square feet per person</p> <p>*Room 104, 2 beds, 216 total square feet. 108 square feet per resident.</p>	F0458	<p>1) All residents have the potential to be affected. An audit of current residents was completed to ensure that no residents were affected by this practice.2) The facility has applied for a waiver related to room size for identifiedrooms: 100, 101, 103, 104, 108, 109, 110, 111, 112, 114, 116, 118, 204, 205, 206, 207, 211, 213, 215, 226, 105 and 107.</p>	02/08/2013

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 01/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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>*Room 108, 1 large bed, 216 total square feet. 216 square feet per resident.</p> <p>*Room 110, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 112, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 114, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 116, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 118, 2 beds, 211.5 total square feet. 105.75 square feet per resident.</p> <p>*Room 204, 2 beds, 216 total square feet. 108 square feet per resident.</p> <p>*Room 205, 2 beds, 212.9 total square feet. 106.45 square feet per resident.</p> <p>*Room 206, 2 beds, 215.3 total square feet. 107.65 square feet per resident.</p> <p>*Room 207, 2 beds, 213.6 total square feet. 213.6 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 01/18/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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>*Room 211, 2 bed, 213.6 total square feet. 106.8 square feet per resident.</p> <p>*Room 213, 2 beds, 213.6 total square feet. 106.8 square feet per resident.</p> <p>*Room 215, 2 beds, 213.6 total square feet. 106.8 square feet per resident.</p> <p>*Room 226, 2 beds, 216 total square feet. 108 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, 1 bed, 141 total square feet. 141 square feet per resident.</p> <p>*Room 103, 1 bed, 144 total square feet. 144 square feet per resident.</p> <p>*Room 109, 1 bed, 143 total square feet. 143 square feet per resident.</p> <p>*Room 111, 1 bed, 143 total square feet. 143 square feet per resident.</p> <p>3. The following resident rooms were certified SNF/NF for one bed and measured less than 100 square feet.</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 01/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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>*Room 105, 1 bed, 91.6 total square feet. 91.6 square feet per resident.</p> <p>*Room 107, 1 bed, 91.6 total square feet. 91.6 square feet per resident.</p> <p>3.1-19(l)(2)</p>			