STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	09/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVE LA PORTE, IN 46350

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 19, 20, 21, 22, and 25, 2017. Facility number: 000061 Provider number: 155136 AIM number: 100288620 Census Bed Type: SNF/NF: 115 Total: 115 Census Payor Type: Medicare: 15 Medicaid: 91 Other: 9 Total: 115 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/28/17.	F 0000		
F 0224 SS=D Bldg. 00	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP			

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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	RIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, Based on record review and interview, the facility failed to ensure each resident was free from misappropriation of property related to drug diversion for 3 of 3 residents reviewed for misappropriation of property. (Residents 32, 38, and 72) Findings include: 1. The record for Resident 32 was reviewed, on 9/22/17 at 12:20 p.m. Diagnoses included, but were not limited to, heart failure and spinal stenosis. A Physician's order, dated 9/30/15,	F 0224	Step One: The Norco Tablets were replaced by the facility for Resident #32, #38, and #78. Step Two: All current residents with orders for controlled substances were reviewed and all medication counts were correct.	10/25/2017

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	indicated the resident was to receive Norco (a pain medication) 7.5-325 mg (milligrams). Give 1 tablet every 4 hours as needed (prn) related to generalized pain. The Significant Change Minimum Data Set (MDS) assessment, dated 8/20/17, indicated the resident was severely cognitively impaired and he received a scheduled pain medication regimen due to occasional pain. A current and updated plan of care indicated the resident had pain related to spinal stenosis. The interventions included, but were not limited to, give medications as ordered. A Nursing Progress Note, dated 8/9/17 at 3:56 p.m., indicated as needed medications were dispensed from the ADU (Automated Dispensing Unit) and not accounted for. Review of the 8/2017 MAR (Medication Administration Record) indicated no prn Norco was administered to the resident on 8/8/17. Interview with the Director of Nursing on 9/22/17 at 11:20 a.m., indicated on 8/9/17, she conducted a record review of the ADU from the previous day's		Step Three: The Licensed Nursing Staff were re-educated regarding the Abuse Policy and the Administration of Controlled Substance. The DNS and/or designee will audit the ADU Controlled Dispense Log and the Narcotic Count Sheets three times weekly to ensure accountability and report the findings to the QAPI Committee monthly. Step Four: The results of the Controlled Substance Audit will be reviewed at the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. After six months of review without any deficiencies, the results will be reviewed quarterly.	

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	activities. She noted, on 8/8/17 at 12:01 p.m., LPN 1 dispensed six Norco tablets which were not administered to Resident 32 during her shift. The resident did not receive any prn Norco tables on 8/8/17. The LPN declined a scheduled in-person interview to verify the disbursement of the medications and was subsequently terminated. The facility was unable to confirm what happened to the medications. 2. The record for Resident 38 was reviewed, on 9/22/17 at 1:10 p.m. Diagnoses included, but were not limited to, cerebral infarct, vascular dementia, major depression, and anxiety. A Physician's order, dated 11/24/14, indicated the resident was to receive Norco (a pain medication) 5-325 mg (milligrams). Give 1 tablet every 4 hours as needed (prn) related to generalized pain. The Quarterly Minimum Data Set (MDS) assessment, dated 6/26/17, indicated the resident was severely cognitively impaired and she received a scheduled pain medication regimen due to occasional pain. A Nursing Progress Note, dated 8/9/17 at 4:02 p.m., indicated as needed			

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	medications were dispensed from the ADU (Automated Dispensing Unit) and not accounted for. Review of the 8/2017 MAR (Medication Administration Record) indicated no prn Norco was administered to the resident on 8/8/17. Interview with the Director of Nursing on 9/22/17 at 11:20 a.m., indicated on 8/9/17 she conducted a record review of the ADU from the previous days activities. She noted, on 8/8/17 at 12:02 p.m., LPN 1 dispensed six Norco tablets which were not administered to Resident 38 during her shift. The resident did not receive any prn Norco tables on 8/8/17. The LPN declined a scheduled in-person interview to verify the disbursement of the medications and was subsequently terminated. The facility was unable to confirm what happened to the medications. 3. The record for Resident 78 was reviewed, on 9/22/17 at 12:38 p.m. Diagnoses included, but were not limited to, chronic kidney disease and hemodialysis. A Physician's order, dated 12/23/15, indicated the resident was to receive Norco (a pain medication) 5-325 mg			

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	(milligrams). Give 1 tablet every 4 hours as needed (prn) related to generalized pain. The Quarterly Minimum Data Set (MDS) assessment, dated 8/31/17, indicated the resident was alert and oriented and she received a scheduled pain medication regimen. A current and updated plan of care indicated the resident had pain related to hemodialysis. The interventions included, but were not limited to, give medications as ordered. A Nursing Progress Note, dated 8/9/17 at 3:47 p.m., indicated as needed medications were dispensed from the ADU (Automated Dispensing Unit) and not accounted for. Review of the 8/2017 MAR (Medication Administration Record) indicated no prn Norco was administered to the resident on 8/8/17. Interview with the Director of Nursing, on 9/22/17 at 11:20 a.m., indicated on 8/9/17 she conducted a record review of the ADU from the previous days activities. She noted, on 8/8/17 at 12:02 p.m., LPN 1 dispensed six Norco tablets which were not administered to Resident			

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	78 during her shift. The resident did not receive any prn Norco tables on 8/8/17. The LPN declined a scheduled in-person interview to verify the disbursement of the medications and was subsequently terminated. The facility was unable to confirm what happened to the medications. 3.1-28(a)			
F 0406 SS=D Bldg. 00	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. Based on record review and interview, the facility failed to ensure specialized rehabilitation services were provided	F 0406	Step One: The 2017 Yearly Resident Review was completed for Resident #118.	10/25/2017

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	related to the lack of a yearly resident review for a mentally ill resident for 1 of 1 residents reviewed for a Preadmission Screen Record Review (PASRR). (Resident 118) Finding includes: The record for Resident 118 was reviewed, on 9/20/17 at 2:19 p.m. Diagnoses included, but were not limited to, delusional disorders, anxiety, and insomnia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/3/17, indicated the resident was alert and oriented. The resident had no behaviors. The Certification of PASRR/MI Preadmission Screening Determination, dated 2/9/16, indicated the resident's psychiatric diagnosis was delusional disorders and required medication administration, medication monitoring, and a yearly resident review. There was no documentation to indicate the 2017 yearly resident review was completed. Interview with the Social Service Director (SSD), on 9/21/17 at 8:34 a.m., indicated the resident's yearly review was		Step Two: All current residents who require a Level II were reviewed for completion of a Yearly Resident Review. Any deficiencies noted were corrected. Step Three: The Social Services Director was re-educated regarding completion of the Yearly Resident Review. The Executive Director and/or designee will audit three residents monthly to ensure the completion of the Yearly Resident Review and report findings to the QAPI Committee monthly. Step Four: The results of the Yearly Resident Review Audit will be reviewed at the Management Meeting weekly. The results will also be reviewed monthly by the	

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	not completed. She was unaware that it was her responsibility to contact their service provider to schedule the resident reviews. The service provider was to be contacted on 9/25/17. Interview with the Director of Nursing, on 9/22/17 at 11:20 p.m., indicated the Level ll yearly reviews should have been completed for all required residents. The SSD was to contact their service provider on 9/25/17 to schedule the assessments. 3.1-23(a)		QAPI Committee for six months. After six months of review without any deficiencies, the results will be reviewed quarterly.	
F 0441 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must			

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	include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to			

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	prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure an infection control program was followed related to the lack of a water management policy and plan to protect high risk residents residing in the facility. Finding includes: Interview with the Administrator, on 9/25/17 at 9:40 a.m., indicated there was no water management system policy or plan in place to monitor for Legionella (bacteria) in the water at the current time. Interview with the Administrator, on 9/25/17 at 1:15 p.m., indicated the Maintenance Supervisor was not aware of any water management system to monitor and test the water for Legionella. The Administrator indicated the facility did have a circulating valve installed so the water did not pool when the water level was low. Observation during the survey indicated there were no hot tubs at the facility and one decorative fountain. The Resident Census & Condition report	F 0441	Step One: No residents were affected by this practice. Review of the current Infection Control Surveillance Log did not reveal any resident with signs or symptoms of Legionnaire's Disease. Step Two: Infection Control Surveillance Logs were reviewed for the past six months and no signs or symptoms of Legionnaire's Disease were noted. Step Three: A Water Management Policy and Procedure was approved and implemented. A Water Management Team was formed including the Executive Director, Director of Nursing Services, Director of Staff Development/Infection Control Nurse, and the	10/25/2017

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	indicated 10 of the 115 residents received respiratory treatments. Facility records indicated 8 of the 115 residents smoked cigarettes and none received chemotherapy. Interview with the Medical Records Director, on 9/25/17 at 1:20 p.m., indicated six residents in the facility were age 50 or younger. Interview with the Director of Nursing, on 9/25/17 at 1:10 p.m., indicated there were no whirlpool bath tubs available in the facility. 3.1-18(a)		Maintenance Supervisor to ensure the control measures are in place. The Water Management Team and Nursing Staff were educated on the Water Management Policy and Procedure. The Executive Director and/or designee will conduct a Water Management Audit monthly and report findings to the QAPI monthly. Step Four: The results of the Water Management Audit will be reviewed at the Management Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. After six months of review without any deficiencies, the results will be reviewed quarterly.	
F 0465 SS=B Bldg. 00	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for			

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	residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation and interview, the facility failed to provide a functional and sanitary environment related to stained call light cords, marred walls, chipped paint, loose baseboards and dirty floor tile on 4 of 4 units throughout the facility. (Rainbow, Terrace Villa, Terrace Garden and Memory) Findings include: During the Environmental tour on 9/25/17, at 12:25 p.m., with the Maintenance Supervisor, the following was observed: 1. The Rainbow Unit a. The pull cord for the bathroom call light in Room 4 was stained and discolored. One resident resided in this room. b. The pull cord for the bathroom call light in Room 7 was stained and discolored. Three residents shared this restroom.	F 0465	Step One: The items cited for Rainbow Lane: pull cords, baseboards, and Air Conditioner Unit were replaced or repaired. The items cited for Terrace Villa: floors, baseboards, and chair rails were cleaned, repaired, or replaced. The items for Terrace Gardens: baseboards and the kitchen table were repaired or replaced. The items for Memory Lane: marred/scratched walls were repaired. Step Two: The Executive Director and Maintenance Supervisor conducted an Environmental Round of the facility. Any deficiencies noted were corrected. Step Three: Staff Members	10/25/2017

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	c. The pull cord for the bathroom call light in Room 8 was stained and discolored. Two residents shared this restroom. d. The pull cord for the bathroom call light in Room 10 was stained and discolored. The baseboard in the bathroom was loose and pulling away from the wall. One resident resided in this room. e. The pull cord for the bathroom call light in Room 12 was stained and discolored. The baseboard behind the toilet was peeling away from the wall. Two residents shared this restroom. f. The pull cord for the bathroom call light in Room 13 was stained and discolored. The baseboard located outside of the bathroom was loose and pulling away from the wall. Two residents resided in this room. g. The base of the air conditioning unit was cracked in Room 16. The edge of the wall located by the closet doors were marred. There were areas of chipped and bubbling paint in the bathroom behind the toilet. The wall next to the bathroom closet was marred. Two residents resided in this room.		were re-educated regarding use of the Building Engines System to report repair needs. Housekeeping and Maintenance Staff were re-educated on the importance of completing routine maintenance and housekeeping rounds. The Executive Director and/or designee will complete environmental rounds weekly and report findings to the QAPI Committee monthly. Step Four: The results of the Environmental Audit will be reviewed at the Management Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. After six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.	

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	h. The pull cord for the bathroom call light in Room 19 was stained and discolored. One resident resided in this room. i. The pull cord for the bathroom call light in Room 26 was stained and discolored. One resident resided in this room. 2. The Terrace Villa Unit a. There was a brown substance on the floor and on the baseboard behind the toilet in Room 102. Two residents shared this restroom. b. The walls and baseboards were marred in Room 109. The baseboard behind the toilet in the bathroom was stained with a brown substance. Two residents shared this restroom. c. The chair rail in the sitting room was scratched and marred. There were also areas of bubbling paint along the baseboard. d. The chair rail and walls in the dining room were scratched and marred. 3. The Terrace Garden Unit a. There was a brown substance on the			

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	155136	A. BUILDING 00 B. WING	09/25/2017

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	baseboard behind the toilet in Room 113. Two residents shared this restroom. b. The baseboard next to the shower room was loose and peeling away from the wall. c. The top of the kitchen table in Room 125 was scratched and marred. 4. The Memory Unit a. The walls in Room 222 were scratched and marred. One resident resided in this room. Interview with the Maintenance Supervisor at the time, indicated all of the above areas were in need of cleaning and/or repair. 3.1-19(f)			
F 9999 Bldg. 00	3.1-14 Personnel (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6)	F 9999	Step One: No Residents were found to be affected by this deficient practice. LPN # 2 has been completed the 3 hours of dementia training. Dietary Employee # 1 has completed the 3 hours of dementia	10/25/2017

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	months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure personnel records were complete, related to dementia training for 5 of 10 employee files reviewed. (LPN 2, Dietary Employee 1, MDS Coordinator 1, CNA 1, and Activity Assistant 1) Findings include: Employee files were reviewed, on 9/25/17 at 11:00 a.m., and the following were not included in the Personnel Files: 1. LPN 2 (hired 5/30/13): The required 3 hours of Dementia training were not completed. 2. Dietary Employee 1 (hired 12/17/15): The required 3 hours of Dementia training were not completed.		training. MDS Coordinator hired on 4-23-10 has completed the 3 hour dementia training. CNA # 1 has completed the 3 hours of dementia training and Activity Asst # 1 has completed the 3 hours of education on dementia training. Step Two: To ensure no other residents have the potential to be affected by the same deficient practice we have performed an audit by which all staff would be identified for lack of the 3 to 6 hour dementia training in-services. The Audit is to ensure deficient practice has not and does not recur. Step Three: Our Alzheimer's Care Director and our Director of Education will report monthly to QAPI showing audit results each month for six months. With positive regulatory trends we will complete audits quarterly	

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	3. MDS Coordinator (hired 4/23/10): The required 3 hours of Dementia training were not completed. 4. CNA 1 (hired 1/20/15): The required 3 hours of Dementia training were not completed. 5. Activity Assistant 1 (hired 2/27/14): The required 3 hours of Dementia training were not completed. Interview with the Human Resources Director, on 9/25/17 at 12:25 p.m., indicated the above employees had not completed the required 3 hours of Dementia training. 3.1-14(u)		thereafter to ensure the deficient practice does not recur. The Executive Director or designee will monitor the outcomes in QAPI for the 3 hour specific dementia training and education to ensure the deficient practice does not recur. Step Four: The results of the 3 hour dementia in-service trainings will be reviewed at the Management Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six month. After six months of review without any negative trends or patterns noted we will continue to review the results in QAPI quarterly monitored by the Executive Director and Director of Education.	