STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	01/27/2017

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00218235, IN00219453, and IN00220113. This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on December 9, 2016. Complaint IN00218235 - Unsubstantiated due to lack of evidence. Complaint IN00219453 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441. Complaint IN00220113 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241, F246, F315, and F441. Survey dates: January 25, 26, and 27, 2016. Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census bed type: SNF: 152 Total: 152	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Jason Eastlund, BSW, HFA	

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: 23 Medicaid: 115 Other: 14 Total: 152 Sample: 25 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 1/31/17.			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on observation, and interview, the facility failed to ensure each resident's dignity was maintained related to urinary catheter drainage bags not covered with a dignity bag for 2 of 3 residents reviewed for dignity. (Resident D and Resident E)	F 0241	Res Identified Residents D and E both had their urine drainage bags placed in dignity bags and hung on the bed. If the bed had to be in the low position, a plastic bad was placed over the dignity bag to protect it from the	02/24/2017

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	Findings include: 1. On 1/25/17 at 2:10 a.m., Resident D was observed in her room in bed. The resident's urinary catheter drainage bag was directly on the floor underneath the resident's bed, and not inside a dignity bag. The record for Resident D was reviewed on 1/26/17 at 1:30 p.m. The resident's diagnoses included, but were not limited to, alzheimers disease, chronic obstructive pulmonary disease, insomnia, chronic kidney disease - stage 3, and flaccid neuropathic bladder The current and updated plan of care, dated 12/30/16, indicated the resident had an indwelling urinary catheter related to flaccid neuropathic bladder. The interventions included, but were not limited to, provide assistance with toileting and incontinence care as needed, and assist with changing brief as needed. 2. On 1/25/17 at 2:24 a.m., Resident E was observed in her room in bed. At that time, the urinary catheter drainage bag was laying on the floor uncovered. The record for Resident E was reviewed on 1/26/17 at 10:40 a.m. The diagnoses included, but were not limited to,		ground. Others All patients with urine drainage bags were observed during the night shift to ensure that they were in dignity bags and not on the floor. Education All clinical staff were educated on maintaining dignity specifically related dignity bags or covers for urine drainage bags and keeping them off the floor. Monitor All residents with urine drainage bags will be reviewed on all shifts 1 X per week X 4 weeks, 1 X per month for 3 months, and then quarterly until 95% compliance is achieved. QAPI Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	

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	dementia with behavioral disturbances, pseudobulbar affect, insomnia, hemiplegia, and anxiety disorder. The current and updated plan of care, dated 12/30/16, indicated the resident had an indwelling urinary catheter. The interventions included, but were not limited to, catheter care per staff. Interview with LPN #1 on 1/25/17 at 3:05 a.m., indicated the urinary catheter drainage bags should not have been on the floor and uncovered. Interview with Unit B Manager on 1/26/17 at 1:26 p.m., indicated the urinary catheter drainage bags should not be on the floor and uncovered. This Federal tag relates to Complaint IN00220113. 3.1-3(t)			
F 0246 SS=D Bldg. 00	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES			

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	(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation and interview, the facility failed to ensure residents had their call lights within reach for 3 of 3 random observations on the B unit. (Resident C, D, and E) Findings include: 1. During initial tour on 1/25/17 at 2:10 a.m., the following was observed: B unit a. Resident C was observed in his room in bed. The resident's call light was observed on the floor tangled in the bed rail. b. Resident D was observed in her room in bed. The resident's call light was observed on the floor. c. Resident E was observed in her room in bed. The resident's call light was observed on the floor by the night stand. . Interview with LPN #1 on 1/25/17 at 2:40 a.m., indicated the residents should have had their call light within reach.	F 0246	Res Identified Residents C, D and E had their call light put in place by staff during the initial tour. Others All residents had their call light checked to ensure that it was accessible and within reach Education All licenses staff were in serviced on call light placement for residents. Monitor Facility will audit one unit per week x 4 weeks, then one unit per month for 3 months then quarterly until 95% compliance is achieved. Facility will look to identify any common trends with call light placement. Facility will look on all shifts to ensure call lights are accessible to residents. QAPI Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are	02/24/2017

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	Interview with Unit B Manager on 1/26/17 at 1:26 p.m., indicated the call light should be within reach of the residents at all time. This Federal tag relates to Complaint IN00220113. 3.1-3(v)(1)		identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	
F 0315 SS=D Bldg. 00	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was			

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	necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services to prevent infection related to urinary catheter drainage bags positioned on the floor for 2 of 3 residents reviewed for urinary catheter use. (Residents D and E) Findings include: 1. On 1/25/17 at 2:10 a.m., Resident D was observed in her room in bed. The resident's urinary catheter drainage bag was directly on the floor underneath the resident's bed and not inside a dignity bag.	F 0315	Res Identified Residents D and E both had their urine drainage bags placed in dignity bags and hung on the bed. If the bed had to be in the low position, a plastic bag was placed over the dignity bag to protect it from the ground. Others All patients with urine drainage bags were observed during the night shift to ensure that they were in dignity bags and not on the floor.	02/24/2017

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	The record for Resident D was reviewed on 1/26/17 at 1:30 p.m. The resident's diagnoses included, but were not limited to, alzheimers disease, chronic obstructive pulmonary disease, insomnia, chronic kidney disease - stage 3, and flaccid neuropathic bladder The current and updated plan of care, dated 12/30/16, indicated the resident had an indwelling urinary catheter related to flaccid neuropathic bladder. The interventions included, but were not limited to, provide assistance with toileting and incontinence care as needed, and assist with changing brief as needed. 2. On 1/25/17 at 2:24 a.m., Resident E was observed in her room in bed. At that time, the urinary catheter drainage bag was laying on the floor uncovered. The record for Resident E was reviewed on 1/26/17 at 10:40 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, pseudobulbar affect, insomnia, hemiplegia, and anxiety disorder. The current and updated plan of care, dated 12/30/16, indicated the resident had an indwelling urinary catheter. The		Education All clinical staff were educated on maintaining dignity specifically related dignity bags or covers for urine drainage bags and keeping them off the floor. Monitor All residents with urine drainage bags will be reviewed on all shifts 1 X per week X 4 weeks, 1 X per month for 3 months, and then quarterly until 95% compliance is achieved. QAPI Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	

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	interventions included, but were not limited to, catheter care per staff. Interview with LPN #1 on 1/25/17 at 3:05 a.m., indicated the urinary catheter drainage bags should not have been on the floor and uncovered. Interview with Unit B Manager on 1/26/17 at 1:26 p.m., indicated the urinary catheter drainage bags should not be on the floor. The current Catheter (Indwelling), Insertion and Removal of (Female and Male) Care Policy, provided by the Administrator on 1/27/17 at 1:30 p.m., indicated urinary catheter drainage bags and tubing were to kept off the floor at all times. This Federal tag relates to Complaint IN00220113. 3.1-41(a)(2)			

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F 0441 SS=D 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 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			

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	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 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 infection control policies and procedures were maintained related to following isolation precautions and a soiled incontinence brief on the floor for 2 of 2 residents observed. (Residents B and C) Findings include:	F 0441	Res Identified The employees who went into Resident B's isolated room were educated immediately. The soiled brief in resident C's room was disposed of properly. Others	02/24/2017

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	1. On 1/26/17 at 9:24 a.m., the Physical Therapist (PT) was observed exiting Resident B's room with gloved hands, in her gloved right hand was a wadded piece of white linen. She walked down the hallway past the nursing station to the soiled utility room, where she entered the security code on the door panel and entered the room. She was then observed walking back down the hallway and re-entering the resident's room. She was not observed wearing a gown when she left the room, nor was she observed putting on a gown when she re-entered the room. Her hands remained gloved during the entire observation. Interview at the time with the Unit Manager, indicated the resident was on contact isolation for Clostridium Difficile (C. diff) a gastro-intestinal infection. The record for Resident B was reviewed on 1/26/17 at 1:39 p.m. Diagnoses included, but were not limited to, cerebral infarction, hemiplegia, diabetes, and hypertension. The 30-day Minimum Data Set (MDS) assessment, dated 1/13/17, indicated the resident was severely impaired for decision making. The resident needed extensive assistance with a two person physical assist for bed mobility and transfers.		Facility managers did room rounds to identify any infection control issues. Education DCE/designee educated all staff related Infection control policy. Monitor DON/Designee will review all rooms for infection control issues 1 X per week for 4 weeks, 1 X per month for 3 months and then quarterly until 95% compliance is achieved. Facility leadership will observe care for patients in isolation 5 X per week for 4 weeks, 5 X per month for 3 months and then quarterly until 95% compliance is achieved. QAPI Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	

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	A Physician's order dated 12/19/16 indicated contact isolation for C. diff. Interview with the PT on 1/26/17 at 1:06 p.m., indicated she was in the room completing an assessment on the resident's bilateral legs and noticed her flat sheet was disheveled. She then straightened the sheet and noticed that it was soiled with feces. She removed the sheet and disposed of it in the soiled utility room. She did not don a gown before entering the room, she did not double bag the soiled sheet before leaving the room, she did not remove her gloves and wash her hands before leaving the room, nor did she don a gown before re-entering the room. Interview with the Clinical Educator on 1/26/17 at 9:55 a.m., indicated the PT did not follow the facilities contact isolation precautions. 2. On 1/26/17 at 1:20 p.m., CNA #1 was observed in Resident B's room standing near the foot of her bed, she did not have on gloves, nor did she have on a gown, at that time the Director of Nursing (DON) called out to the CNA from the resident's doorway as she was attempting to don clean gloves. She instructed her to place on a gown, the CNA then stated to the			

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	DON she was told to don a gown if she was going to be changing the resident. Interview with the Clinical Educator on 1/26/17 at 1:25 p.m., indicated all staff were to don a gown and gloves when entering the resident's room. The CNA should have gowned and gloved before entering the room. The current Clostridium Difficile policy, dated 8/2014 and provided by the Administrator on 1/26/17 at 10:08 a.m., indicated " Residents with diarrhea associated with C. diff (i.e., residents who are colonized and symptomatic) will be placed on Contact Precautions. Healthcare workers will wear gloves and gowns upon entering the room of a resident with C. difficile infection, and will remove gloves and gowns prior to exiting the room. 3. On 1/25/17 at 2:10 a.m., during the initial tour, a soiled brief was observed on the floor near the garbage can in Resident C's room. The record for Resident C was reviewed on 1/25/17 at 1:30 p.m. Diagnoses included, but were not limited to, Parkinson's disease, mood disorder, abnormal gait and mobility, and psychotic disorder with delusions. Interview with LPN #1 on 1/25/17 at 2:33 a.m., indicated the soiled brief did not belong on the floor, and should have			

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	been thrown away. Interview with Unit B Manager on 1/26/17 at 1:26 p.m., indicated the soiled brief should not be on the floor, and should have been thrown in the garbage. This Federal tag relates to Complaints IN00219453 and IN00220113. 3.1-18(a)			