

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

PRINTED: 09/04/2019

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/15/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	<p>This visit was for the Investigation of Complaints IN00303258 and IN00302643.</p> <p>Complaint IN00303258 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00302643 - Substantiated. Federal/State deficiencies related to the allegations are cited at F559.</p> <p>Survey dates: August 14 &amp; 15, 2019</p> <p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Census Bed Type: SNF/NF: 80 Total: 80</p> <p>Census Payor Type: Medicare: 6 Medicaid: 57 Other: 17 Total: 80</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed on August 19, 2019.</p>	F 0000	-	
F 0559 SS=D Bldg. 00	<p>483.10(e)(4)-(6) Choose/Be Notified of Room/Roommate Change</p> <p>§483.10(e)(4) The right to share a room with his or her spouse when married residents live</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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/15/2019
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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>in the same facility and both spouses consent to the arrangement.</p> <p>§483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.</p> <p>§483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.</p> <p>Based on record review and interview, the facility failed to provide residents with written room change notification prior to changing resident rooms for 2 of 3 residents reviewed for room changes. (Resident B &amp; C)</p> <p>Finding includes:</p> <p>1. During on interview, 8/15/19 at 9:45 A.M., Resident B indicated he was given a 30 minute notice he was changing rooms and staff had just come into his room, started packing his belongings and moved him into a room he did not have the option to choose. Resident B moved into the semi-private room already occupied by Resident C.</p> <p>The record for Resident B was reviewed on 8/14/19 at 9:49 A.M. The diagnoses included, but were not limited to, congestive heart failure and maniac depression.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 7/16/19, indicated Resident B had a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact and was independent with ambulation using a walker.</p>	F 0559	<p><b>F0559- Requesting desk review-paper compliance.</b></p> <p>ACTION TAKEN: Upon notification of finding on 08/15/2019, an AD-HOC QAPI was initiated and shown to State Surveyors for review. The Social Service Director and Staff were in serviced on the policy and procedure along with the transfer form on "Room and Discharge".</p> <p>IDENTIFICATION OF OTHER RESIDENTS: The facility did an audit of other residents and no other residents were noted at risk.</p> <p>MEASURES IN PLACE: The facility has a policy in place for room transfers and discharges along with forms to document notification.</p> <p>MONITORING OF CORRECTIVE ACTION: The Social Service Director will monitor and audit with the "Room Move Audit Tool" 3 days a week times 3 months then, weekly times 3 months. The</p>	09/13/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/15/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
---	---

(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>Confidential staff interviews were conducted between 8/14/19 at 10:30 AM and 8/15/19 at 12:00 PM. The following interviews were as indicated:</p> <p>Staff 1 indicated Resident B was moved to the room already occupied by Resident C at the request of administration on 8/12/19 due to not having a payor source and it was not an appropriate room for him to be placed in.</p> <p>Staff 2 indicated Resident B was moved to room already occupied by Resident C at the request of administration 8/12/19 to moving to a semi-private room due to no payor source and it was not an appropriate room for the resident to be placed in.</p> <p>A progress note, dated 8/12/19 at 10:00 A.M., indicated Social Services had spoke with Resident B about moving to B wing.</p> <p>A Progress note, dated 8/12/19 at 4:06 P.M., indicated Resident B was expressing anger about his move to B wing.</p> <p>There was no documentation available for written notice of room change provided to Resident B.</p> <p>2. The record for Resident C was reviewed on 8/14/19 at 9:39 A.M. The diagnoses included, but were not limited to, depression and asthma.</p> <p>The significant change MDS (Minimum Data Set) assessment, dated 6/4/19, indicated Resident C had a BIMS (Brief Interview of Mental Status) score of 13, cognitively intact and was independent with locomotion using a wheelchair.</p> <p>A care plan, dated 2/28/19, indicated Resident C continued to urinate and have feces on the floor</p>		Executive Director and or Director of Nursing will monitor the forms and compliance Monday through Friday daily in morning meeting x 3 months. Room moves will be discussed prior by IDT. All results will be reported and reviewed by the QAPI committee.	

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

PRINTED: 09/04/2019

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/15/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP COD 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
---	--

(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>despite staff educations on health risks, sanitation risk and risks of infection.</p> <p>On 8/12/19 Resident B was moved into the same room as Resident C.</p> <p>There was no documentation available for written notice of a new roommate provided to Resident C.</p> <p>During an interview, on 8/15/19 at 11:59 P.M., the Social Service Director indicated Resident C was not provided a written notice of receiving a new roommate prior to Resident B moving into the room on 8/12/19 and she indicated the facility should have followed their policy.</p> <p>On 8/14/19 at 12:50 P.M., the ED (Executive Director) provided the "Resident Room Relocation" policy, dated 12/2/16, and indicated this was the policy currently being used by the facility. The policy indicated "the resident had the right to receive written notice, including the reason for the change, before the resident's room or roommate was changed. Social service staff would develop a plan to assure that needs and concerns related to the resident's ability to cope and adjust to the relocation were addressed by taking the following steps: Providing resident with a written notice and documenting in the medical record, giving the resident option of room choice, introducing resident to new roommate, informing resident when he/she was receiving a new roommate...."</p> <p>This Federal tag relates to Complaint IN00302643.</p> <p>3.1-3(v)(2)</p>			