PRINTED: 09/27/2018

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155323	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPLETED 08/31/2018	
	PROVIDER OR SUPPLIES			410 TI	ADDRESS, CITY, STATE, ZIP COD OGA RD		
	EW VILLAGE SENIC	OR LIVING	MONTICELLO, IN 47960				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	p.	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	ÍATE	COMPLETION
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DELICE NO.		DATE
F 0677 SS=D Bldg. 00	Licensure Survey. Survey dates: Augustian Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type Medicare: 4 Medicaid: 23 Other: 2 Total: 29 These deficiencies accordance with 41 Quality review community and the second seco	55323 67580 : reflect State Findings cited in 0 IAC 16.2-3.1.	F 00	000	Submission of this Plan of Correction does not constitute admission or an agreement of provider of the truth of facts alleged or corrections set for the statement of deficiencies Plan of Correction is prepare submitted because of requirements under state an federal law. Please accept the Plan of Correction as our creallegation of compliance. Prodesires to request a desk review of a re-visit due to monit in place to substantiate the allegation of compliance. Christopher J. Schiavone, H. Administrator	th on The d and d his edible ovider view in oring	
		and record review, the facility owers per resident preference	F 0	677	A shower was provided immediately for resident 20.	t	09/28/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

to a resident who required total assistance with

residents reviewed for choices. (Resident 20)

activities of daily living (ADL's) for 1 of 1

TITLE

this time.

Resident preferences were again

no significant changes indicated at

discussed with the resident with

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	
	_

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155323		JILDING	ONSTRUCTION 00	(X3) DATE COMPL 08/31 /	ETED	
	PROVIDER OR SUPPLIER		410 TIC	ADDRESS, CITY, STATE, ZIP COD OGA RD CELLO, IN 47960		
	W VILLAGE GEINIG	SIN EIVING	WONT			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL D LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
IAG		R LSC IDENTIFYING INFORMATION	TAG			DATE
	REGULATORY OF Finding includes: Interview with Resindicated she was sweek, but sometime. Interview with Resident 20's record 3:15 p.m. Diagnosolimited to, obesity, cord do not form configh blood pressur rhythm, and mild in A Significant Chan assessment, dated 7 was totally dependent assist and was cognitived assist and was cognitived as a "Daily Preference and indicated show Tuesday and Friday. The "Resident Care received "PB" - Par August 17, 18, 19, 22, and 30 and a shower Interview with CNA	ident 20, on 8/2718 at 3:15 p.m., uppose to get 2 showers a es did not get any showers. ident 20, on 8/31/18 at 10:10 was getting showers "half the d was reviewed on 8/29/18 at es included, but were not spina bifida (spine and spinal breetly at birth), hypertension e), asthma, irregular heart intellectual disabilities. ge Minimum Data Set (MDS) 1/19/18, indicated Resident 20 ant on bathing with a 2 person intively intact. e" form was completed 6/14/18 ers 2 x (times) a week on rs, in the evenings. e Record" indicated Resident 20 tial Bathing, in the evenings on 20, 21, 22, 23, 25, 26, 27, 28, 29,		PROVIDERS PLAN OF CORRECTION (RACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA 2. No other Residents were affected, however, as all resid have the potential to be affecte the following corrective actions shall be taken. 3. All residents were asses to assure proper shower schedules in place. Resident preferences were again discus with all residents, with no significant changes made. Nur staff were re-educated on sho policy for all residents. 4. The shower policy and procedure was reviewed with changes. All nursing staff was re-educated on the proper procedure and importance of showers for all residents and w to do should a Resident refuse their shower. The DON and/or designee will assess 5 resider showers and care 5 x / week x weeks, 3 x /week x 4 weeks th weekly thereafter. Should any concerns be noted, immediate corrective action will be taken. 5. The results of these revie and any corrective action will to reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the frequency	e ents ed, s sed ssed ssed rsing wer no vhat e ats' 4 een	
	8/31/18 8:58 a.m., i completed and review	Director of Nursing (DON) on indicated shower sheets are ewed. If the resident refuses narked refused on the sheet.		monitoring will be increased of decreased according to finding. The above corrective actions to be completed on or before September 28, 2018.	gs.	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155323	A. BUILDING 00 COMPLETED B. WING 08/31/2018				
		100020				00/31/	2010
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD GA RD		
LAKEVIE	W VILLAGE SENIC	DR LIVING		410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F 0679 SS=D	Interview with the N 10:17 a.m., indicate sheet dated August there should have be were none for Augu 3.1-38(a)(3) 483.24(c)(1)	Nurse Consultant on 8/31/18 at d there was only 1 shower 24. If the resident refused, een a behavior note and there ast.		AU			DATE
Bldg. 00	§483.24(c) Activiti §483.24(c)(1) The on the comprehen plan and the preference ongoing program to choice of activities group and individuindependent activities of and surple and psychosocial encouraging both interaction in the compared resident was activities of choice for 1 of 1 residents (Resident 7) Finding includes: On 8/27/18 at 2:46 wheelchair in an op A radio was sitting was not on. There we the area. On 8/28/18 at 2:01 wheelchair in an op	facility must provide, based sive assessment and care rences of each resident, and to support residents in their s, both facility-sponsored all activities and titles, designed to meet the apport the physical, mental, well-being of each resident, independence and	F 0679)	1. Resident 7 was immedia assessed, and family interview to assure resident was provide with preferred activities of choi to meet her individual interests 2. All residents were review with input from family member applicable, to assure they are provided with preferred activitic choice to meet their individual needs. No other Residents we identified as affected. 3. The Activity Director was re-educated by the Administra on 9/5/2018 pertaining to work with residents on preferred activities to meet their individu needs in addition to one on on	ved ed ed ice s. ved, s, if es of re stor ing	09/28/2018

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155323		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/31/2018		
	PROVIDER OR SUPPLIEF		410 TI	ADDRESS, CITY, STATE, ZIP COI OGA RD ICELLO, IN 47960	D	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF other residents were On 8/29/18 at 2:15 wheelchair in an op The radio next to the other residents were Record review for I 8/28/18 at 11:25 a.r were not limited to, and psychotic disor The Significant Cha assessment, dated 6 was cognitively implicated it was ver liked. The Activity Assess dated 6/27/18, indicated to gospel and count and conversing with resident was to have two times a week. Interview with the A 2:17 p.m., indicated activity visits with	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION e around the area. p.m., Resident 7 was sitting in a en area by the nurses station. e resident was not on and no e around the area. Resident 7 was completed on m. Diagnoses included, but dementia, anxiety, depression, der. ange Minimum Data Set (MDS) /13/18, indicated the resident paired. The activity preference by important to have music she estated the resident liked to listen ry music. She enjoyed talking friends, family and staff. The ell on 1 with activities staff Activity Director on 8/29/18 at I she hasn't documented 1 on 1 the resident since March 2018.	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY) documentation. The resi and/or family interviews reviewed and activities implemented to meet the resident's interests. The Director and/or designed monitor 5 residents daily scheduled days of work activities of interest are to followed utilizing the monitorly tools daily times 4 weeks weekly times four weeks every two weeks times to months, then quarterly the to assure residents activitien implemented to meet the individual interests. Should concerns be noted, immonitoring, and any corrective action will be to facility's monthly QA meet an ongoing basis for a mean ongoing basis for a mean ongoing basis for a mean ongoing will be increased decreased according to the above corrective meeting and another means of the above corrective meeting and another means of the above corrective meeting and according to the above corrective meeting according to the according	dent were Activity e will on to ensure peing nitoring s, then s then wo nereafter rities are e resident uld any ediate taken. rective by the etings on ninimum of uency of sed or findings.	(X5) COMPLETION DATE
⁼ 0689 SS=D Bldg. 00	to listen to it anymore recently. She indic			be completed on or befo September 28, 2018.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

IYWO11 Facility ID: 000216

If continuation sheet

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155323	B. WING		08/31/2018	
NAME OF PROVIDER OR SUPPLIER LAKEVIEW VILLAGE SENIOR LIVING (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		410 TIC	ADDRESS, CITY, STATE, ZIP COD DGA RD CELLO, IN 47960	(X5)		
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	• · · · · · · · · · · · · · · · · · · ·	
	remains as free of possible; and §483.25(d)(2)Eacl adequate supervise to prevent accider Based on observation interview, the facility	resident environment accident hazards as is accident hazards as is a resident receives sion and assistance devices ats. on, record review, and ty failed to ensure adequate	F 0689	Resident 7 was re evalu for Elopement risk. All residents were re-	ated 09/28/2018	
	elopement related to assessment for 1 of unsafe wandering/e Finding includes: On 8/27/18 at 11:27 in her wheelchair by entrance. The resid and stating she wan wheeled the residen open area by the nu			2. All residents were re evaluated for elopement risk v no further concerns noted. No other Residents were affected 3. The Elopement risk polic and procedure was reviewed no changes made. All staff was re-educated by the Administration 9/26/2018 pertaining to the Elopement Risk policy and specific procedures to follow it resident is identified as exhibit exit -seeking behaviors. The Social Services designee will	I. Ey with as ator f a ting	
	in her wheelchair at resident was pushin the facility. The res open the back door' wheeled the residen Record review for F 8/28/18 at 11:25 a.r.	a.m., Resident 7 was observed the end of the hall. The g on a door that leads out of sident was saying, "come on, " " I want to leave". A CNA tt away from the door. Resident 7 was completed on n. Diagnoses included, but dementia, anxiety, depression, der.		review residents with exit seel behaviors on a daily basis on scheduled days of work to ensadequate supervision and assistance to prevent unsafe wandering/elopement. The SS and/or designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarter	sure SD e	
	-	ange Minimum Data Set (MDS) /13/18, indicated the resident paired.		thereafter until compliance is obtained and maintained. 4. The results of this monitoring, and any corrective	•	

action will be reviewed by the

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155323		A. BUILDING 00 B. WING			COMPLETED 08/31/2018	
		100020	B. W			06/31/	12010	
NAME OF I	PROVIDER OR SUPPLIER	8		STREET A	ADDRESS, CITY, STATE, ZIP COD			
LAKEVIE	EW VILLAGE SENIC	OR LIVING			CELLO, IN 47960			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDEDIG DI AN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	ted 6/28/18, indicated the			facility's monthly QA meetings			
		several staff members to help o she could go home.			an ongoing basis for a minimu six month and the frequency of			
	ner pack ner bags so	o she could go home.			monitoring will be increased o			
	A Nursing Note, da	ted 7/2/18, indicated the			decreased according to finding			
		sed throughout the shift. She			The above corrective measure	es will		
		exit door insisting she needed			be completed on or before			
	to leave.				September 28, 2018.			
	An Elopement Risk	Assessment, dated 8/18/18,						
	_	nt had the ability to move						
		dependently. The resident did						
	_	to leave the facility or exhibit						
		ors. The resident was not at						
	risk for elopement.							
	Interview with CNA	A 3 on 8/29/18 at 11:00 a.m.,						
		nt had been going to the						
	doors a lot more late	ely trying to leave. She						
	indicated the reside	nt would say she wanted to go						
	get an apartment.							
	Interview with the I	Director of Nursing and the						
		ctor on 8/29/18 at 11:18 a.m.,						
	indicated the reside	nt had voiced wanting to leave						
	-	e had been there but had not						
		If the resident had been						
		ately, staff should have told						
	for elopement.	assess the resident for a risk						
	Tor cropement.							
	3.1-45(a)(2)							
F 0697	483.25(k)							
SS=D	Pain Managemen	t						
Bldg. 00	§483.25(k) Pain M							
	The facility must e	-						
	-	rovided to residents who						
	•	ces, consistent with						
	professional stance	dards of practice, the	- 1				1	

STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155323	B. W	ING		08/31	/2018
		<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			OGA RD		
LAKEVIE	W VILLAGE SENIC	OR LIVING		MONTICELLO, IN 47960			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		erson-centered care plan,					
		goals and preferences.	 E 0/	CO.7	4 Decident 24 was		00/20/2010
		on, record review, and sy failed to monitor and assess	F 00	59/	1. Resident 24 was	_	09/28/2018
		ly impaired resident for 1 of 1			immediately assessed for pair and was noted to have a red,	ı	
		or pain management. (Resident			inflamed area with a white are	o in	
	24)	or pain management. (Resident			the middle, on the inside of	a III	
	~ 1)				Residents 24's cheek.		
	Finding includes:				2. Resident 24 had no neg	ative	
	- mama merades.				outcome as a result, as the	4.110	
	During an observat	ion on 8/27/18 at 11:21 a.m.,			physician was notified on 8/29	/18	
	•	at her lower dentures, pointed			by the Director of Nursing and		
		area and complained of pain to			treatment orders were initiated		
	_	wer tooth area to the Activities			Residents were reviewed with		
		vity Director asked the resident			other Resident being identified		
		candy, the resident replied			have been experiencing pain.		
		es Director said that is why it			other Residents were affected		
	hurts.				3. The pain assessment po	olicy	
					and procedure was reviewed	with	
	During an observat	ion on 8/28/18 at 9:04 a.m.,			no changes. All staff was		
	Resident 24 went to	LPN 1, pointed to her right			re-educated on the proper		
	lower jaw area and	complained that her tooth hurt.			procedure and importance of		
	LPN 1 asked the res	sident if she had brushed her			reporting pain for all residents	and	
		dent did not answer and			what to do should a Resident		
		1 did not further assess, nor			report they are in pain. The Do	NC	
	look in to the reside	ent's mouth.			and/or designee will assess 5		
					residents' pain 5 x / week x 4		
		d was reviewed on 8/29/18 at			weeks, 3 x /week x 4 weeks th		
	_	ses included, but were not			weekly thereafter. Should any		
	limited to, Alzheim				concerns be noted, immediate		
		e language disorder (has			corrective action will be taken.		
		g their needs), intellectual			4. The results of these revi		
	disabilities.				and any corrective action will I	be	
		D (C (C DC)			reviewed during the facility's		
		imum Data Set (MDS)			monthly QA meetings on an		
		7/24/18, indicated the resident			ongoing basis for a minimum		
	was cognitively imp	paired.			six months and the frequency		
	TI	Con Contract Communication Contract Con			monitoring will be increased o		
	<u>-</u>	an Order Summary indicated to			decreased according to finding	-	
	accece nam every ch	IIII AUG II DESSEDI TETET TO THE	1		I THE SHOVE COMPACTIVE SCHOOLS		

STATEMENT OF DEFICIENCIES 2		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155323	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/31/2018		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 410 TIOGA RD MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IT CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE	
	(milligrams) every fever. The Medication Ad the resident was ass did not have any particle. The Nurse Progress of the resident's paid An updated care play resident requires spintervention was to problems such as displayed by the such as displaye	s Notes lacked documentation n. an, dated 8/16/18, indicated the ecial attention to oral care, an observe for oral/dental ryness, ulceration, cracking, Activities Director, on 8/28/18 a.m., indicated she always says and she should have told the		be completed on or before September 28, 2018			
	3.1-37(a)						
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication §483.45(f) Medica The facility must e						
	§483.45(f)(1) Med	lication error rates are not 5					

FORM CMS-2567(02-99) Previous Versions Obsolete

Based on observation, record review, and

Event ID:

IYWO11

F 0759

Facility ID: 000216

If continuation sheet

Residents' 27 and 10 had no

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09/28/2018

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155323	B. W	ING _		08/31/	/2018
				STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			OGA RD		
Ι ΔΚΕ\/IF	EW VILLAGE SENIO	OR LIVING			CELLO, IN 47960		
LAILLVIL	TO VILLAGE GEINIC			WICHTI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	ty failed to ensure a medication			adverse reactions. LPN 2 was	3	
		nn 5% for 2 of 8 residents			re-educated on the use of the		
	observed during 3 medication pass observations.				insulin pen as well as the		
	2 errors in medications were observed during 33				necessity of monitoring the		
	opportunities for er				residents pulse prior to giving		
		s resulted in a medication error			certain cardiac or antihyperter	nsive	
	rate of 6.06%. (Res	idents 2 / & 10)			medication. The physician for	·c. 1	
	Plather to delay				residents' 10 and 27 were not	itied	
	Findings include:				with no new orders received.		
					2. Residents receiving insu	ılın	
	_	ation administration observation			via insulin pen and residents		
		o.m., LPN 2 prepared Resident			receiving cardiac		
		rhich included an insulin pen.			meds/antihypertensive meds		
		e dial on the insulin pen to 5			charts were reviewed to assur	e	
	_	to administer the insulin to			correct administration and		
		m. The LPN did not prime the			monitoring were complete with		
	_	ot (procedure to eliminate air			concerns noted. Nursing staff	were	
		l ensure the correct amount of			re-educated on medication		
		fore administering the insulin			administration with a special for	ocus	
	from the insulin per	1.			on use of insulin pen and	_	
	Dagged raviage for 1	Resident 27 was completed on			monitoring pulse prior to giving	-	
		. The August 2018 Physician			certain cardiac/antihypertensi	ve	
	_	OS) indicated an order for			medication. 3. The medication		
		, to prime and inject 5 units				owod	
	every day.	, to prime and inject 5 units			administration policy was reviewith no changes necessary.	eweu	
	every day.				Nursing staff re-educated as		
	Interview with I PN	V 2 on 8/28/18 at 5:09 p.m.,			above. The DON and/or design	inee	
		't do an airshot before each			will monitor nursing staff giving		
		an airshot is only needed the			insulin injections via insulin pe	-	
	first time you open				and monitoring pulse prior to		
	Jou open	· · · · · · · · · · · · · · · · · · ·			cardiac meds per order for 3	99	
	Interview with the	Director of Nursing on 8/28/18			residents 5 x per week x 4 we	eks.	
		ted they should do an airshot			2 x per week x 4 weeks, and	,	
	_	g the insulin each time.			weekly x 4 weeks then quarte	rlv	
		5			thereafter to assure proper ins	-	
	The insulin pen manufacturing instructions,				administration via insulin pen		
	_	ility on 8/30/18, indicated,			monitoring of pulse as necess		
		ot before each injection. Before			prior to giving cardiac medicat		
	_	Il amounts of air may collect in			as ordered.		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155323	B. W	NG		08/31/	2018
	ROVIDER OR SUPPLIER			410 TIO	ADDRESS, CITY, STATE, ZIP COD OGA RD CELLO, IN 47960		
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PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	_	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	the cartridge during injection of air and dose of insulin" 2. During a medica on 8/28/18 at 5:13 processed to the processed to the processed to the processed to the cartrate is less the resident's room resident's medication resident's heart rate. Record review for From the system of the processed to the p	normal use. To avoid to ensure you take the right tion administration observation o.m., LPN 2 prepared Resident hich included metoprolol essure medication). The icated to hold the medication if than 50. The LPN walked into and administered the n without checking the Resident 10 was completed on The August 2018 POS or metoprolol succinate. Give three times a day. Hold if the			4. The results of these revier and any corrective action will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the frequency monitoring will be increased or decreased according to finding. The above corrective actions where the completed on or before September 28, 2018.	ews pe of of gs.	
	received as current indicated, "20. Al	edication Administration" and from the facility on 8/29/18, ways take pulse and B/P as prior to giving certain cardiac drugs"					
F 0880 SS=D Bldg. 00	infection prevention	on & Control					

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Event ID:

IYWO11 Facility ID: 000216

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155323	B. W	ING		08/31/	/2018
		l .	_	STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		410 TIC			
\ \\\\\	W VILLAGE SENIC				CELLO, IN 47960		
LANEVIE	W VILLAGE SEINIC	JR LIVING		WONT	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	comfortable enviro	onment and to help prevent					
	the development a	and transmission of					
	communicable diseases and infections.						
	§483.80(a) Infection	on prevention and control					
	program.						
		establish an infection					
		introl program (IPCP) that					
		minimum, the following					
	elements:						
		ystem for preventing,					
	identifying, reporting, investigating, and						
		ons and communicable					
		sidents, staff, volunteers,					
		individuals providing					
		contractual arrangement					
	based upon the fa	-					
		ing to §483.70(e) and					
	following accepted	d national standards;					
	0400 00/->/0> \						
		tten standards, policies,					
		or the program, which must					
	include, but are no						
	•	rveillance designed to					
		ommunicable diseases or					
		hey can spread to other					
	persons in the fac						
	` '	hom possible incidents of					
		sease or infections should					
	be reported;	transmission based					
		transmission-based					
	I -	followed to prevent spread					
	of infections;	, inclution about he used					
		visolation should be used					
		uding but not limited to:					
		duration of the isolation, he infectious agent or					
		<u> </u>					
	organism involved						
	(b) A requirement	that the isolation should be					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 00 COMPLETED						
155323			B. WIN	B. WING 08/31/2018					
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD				
				410 TIC					
LAKEVIEW VILLAGE SENIOR LIVING				MONTICELLO, IN 47960					
(X4) ID		STATEMENT OF DEFICIENCIE	_	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE		
TAG		e possible for the resident		TAG			DATE		
	under the circums	•							
		nces under which the facility							
	must prohibit emp	loyees with a							
		ease or infected skin							
		t contact with residents or							
		contact will transmit the							
	disease; and	ene procedures to be							
	1	nvolved in direct resident							
	contact.	TVOIVEU III UIICEL TESIGETIL							
	Contact.								
	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP								
	and the corrective actions taken by the								
	facility.								
	§483.80(e) Linens.								
		andle, store, process, and							
		as to prevent the spread							
	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.								
		on, interview, and record	F 088	30	Resident 9 was not affect		09/28/2018		
	review, the facility failed to ensure infection				LPN 1 and 5 were re-educated	d on			
		ned during a dressing change			proper dressing change and				
		pressure ulcer for 1 of 2			infection control procedures su				
		for pressure ulcer care.			as glove use and hand washir	-			
	(Resident 9) Finding includes: During an observation of Resident 9's dressing change on 8/29/18 at 10:08 a.m. with LPN 1 and				2. Residents with wounds the notential to be affected. All				
					the potential to be affected. All residents with wounds have been				
					assessed for signs and symptom				
					of infection, with no concerns				
					noted.				
		was positioned onto her left			The infection control poli	icy			
	side and the old undated dressing was removed.				and the dressing change polic	:y			
	LPN 1 cleansed the sacral (tailbone area) wound				have been reviewed with no				

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IYWO11 Facility ID: 000216

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PRINTED: 09/27/2018 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED					
155323		B. WING		08/31/2018					
		100020	D. 11110		30/01/2010				
NAME OF B	DOLUBED OD GUDDU ED		STREET	ADDRESS, CITY, STATE, ZIP COD					
NAME OF P	ROVIDER OR SUPPLIER	<u>(</u>	410 TI	OGA RD					
I AKFVIF	W VILLAGE SENIC	OR LIVING		MONTICELLO, IN 47960					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION				
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE				
	and then applied the	e new dressing of silver		changes indicated. Nursing staff					
		me gloved hands and then		have been re-educated on pro					
	-	at covered the silver alginate.							
				dressing change procedure w					
		d a skin protectant on the		special focus on glove use and	-				
	resident's buttock w	ith the same gloved hands.		hand washing. The DON/design	-				
				will monitor dressing changes					
	Interview with LPN	1 after the completion of the		daily 5 x per week x 4 weeks,	2 x				
	dressing change, inc	dicated she had no excuse,		per week x 4 weeks, and wee	kly x				
	she had forgotten to	change her gloves. It is an		4 weeks then quarterly therea	·				
	every day dressing	change, so the bandage does		to assure proper dressing cha					
	not need to be dated. Policy titled, "Dressing-Clean Technique," was provided by the Nurse Consultant on 8/29/18 at 11:13 a.m. This current policy indicated, "Procedure2. Removed soiled dressing and discard into designated waste receptacle. 3. Remove gloves, wash hands, and put on a pair of clean gloves"			procedure.					
				4. The results of these revi	OWE				
				and any corrective action will l	be				
				reviewed during the facility's					
				monthly QA meetings on an					
				ongoing basis for a minimum	of				
				six months and the frequency	of				
				monitoring will be increased or					
				decreased according to finding	as.				
				The above corrective actions	-				
3.1-18(a)				be completed on or before					
	3.1-18(1)			- I					
	3.1-10(1)	,		September 28, 2018.					
F 0024	400.00(:)								
F 0921	483.90(i)								
SS=E		anitary/Comfortable Environ							
Bldg. 00	§483.90(i) Other Environmental Conditions								
	The facility must provide a safe, functional, sanitary, and comfortable environment for								
	residents, staff an	d the public.							
	Based on observation and interview, the facility		F 0921	1.) All items identified in the	09/28/2018				
		functional, safe and homelike	1 0,21	2567 statement of deficiencies					
		I to yellowed discolored pull		have been repaired or replace					
		om, exposed toilet screws,		- A5 bathroom pull cord					
				I					
		n the bathroom, and discolored		replaced immediately					
		hallways. (Hallway A, Hallway		- A5 bathroom toilet flan	ge				
	C and Hallway D)			bowl caps were installed					
				immediately					
	Findings include:			- A1 bathroom tiles that					
				surrounded the toilet has been	, I				

FORM CMS-2567(02-99) Previous Versions Obsolete

During the Environmental Tour on 8/30/18 from

Event ID:

IYWO11

Facility ID: 000216

If continuation sheet

cleaned and repaired immediately.

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW VILLAGE SENIOR LIVING (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREERY (EACH DEFICIENCY MIST BE PRECEDED BY PULL PAGE HOUSE COMPLETION AT 11:90 a.m., with the Administrator, the Director of Maintenance, the Housekeeping-Laundry Supervisor, and the Regional Consultant, the following was observed: 1. A Hallway: 1. A Hallway: 1. A Hallway: 2. C had the non-skid strips removed b. Room 1's bathroom pull cord had a yellow discoloration, the flarge bowl caps were missing on toide with exposed serws. There was one resident who resided in this room. b. Room 1's bathroom floor tiles that surrounded the toilet, had yellow and brown discolorations, there were missing flange bowl caps and exposed nated screws on toilet base, and the bathroom walls were mainly blue with random pink patched areas: There was one resident who resided in this room. 2. C I tallway: a. On Room 2's floor near the bed in use, there were worm non-skid floor strips. There was one resident who resided in this room. 3. D Hallway: a. On Room 3's bathroom wall, there were flour screws stocking out above the inited, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. A BELLIENCE TO, NATHETION TORNETION (XX)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER LAKEVIEW VILLAGE SENIOR LIVING (Ma) ID SUMMARY STATEMENT OF DEFICIENCIE (RACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR ISE DENIFITYING NEROMATION 11-90 a.m11-19 a.m., with the Administrator, the Director of Maintenance, the Housekeeping/Laundry Supervisor, and the Regional Consultant, the following was observed: 1. A Hallway: a. Room 5's bathroom pull cord had a yellow discoloration, the flange bowl caps were missing on toilet with exposed screws. There was one resident who resided in this room. b. Room 1's bathroom floor tiles that surrounded the toilet, had yellow and brown discolorations, there were missing flange bowl caps and exposed rusted screws on toilet base, and the bathroom walls were mainly blue with random pink patched areas. There was one resident who resided in this room. 2. C. Hallway: a. On Room 2's floor near the bed in use, there were worn non-skid floor strips. There was one resident who resided in this room. 3. D. Hallway: a. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and on the dathroom, Interview with Administrator at the end of the tour, indicated the above was in need of repair or cleaming. 3. J. 1-19(c)	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00		
AME OF PROVIDER OR SUPPLIES (ACH COBSETTIVE. THE WAS ON TO SUBMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LECT IDENTIFYING SHORMATION TAG REGULATORY OR LECT IDENTIFY THE WAS ORD REGULATORY OR LECT	155323		B. WING 08/31/2018			2018		
AME OF PROVIDER OR SUPPLIES (ACH COBSETTIVE. THE WAS ON TO SUBMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LECT IDENTIFYING SHORMATION TAG REGULATORY OR LECT IDENTIFY THE WAS ORD REGULATORY OR LECT					STREET A	ADDRESS, CITY, STATE ZIP COD		
LAKEVIEW VILLAGE SENIOR LIVING MONTICELLO, IN 47960	NAME OF P	PROVIDER OR SUPPLIER	L					
Ox 1D SUMMARY STATEMENT OF DEFICIENCE PREFIX (HACH DEFICIENCY MIST BIT PRECEDID BY TELL TAG REGULATORY OR LES DEMINIFATION TAG REGULATORY OR LES DEMINIFATION TAG REGULATORY OR LES DEMINIFATION TAG	LAKEVIEW VILLAGE SENIOR LIVING							
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 11:00 a.m11:19 a.m., with the Administrator, the Director of Maintenance, the Housekeeping Laundry Supervisor, and the Regional Consultant, the following was observed: 1. A Hallway: a. Room 5's bathroom pull cord had a yellow discoloration, the flange bowl caps were missing on toilet with exposed screws. There was one resident who resided in this room. b. Room 1's bathroom floor tites that surrounded the toilet, had yellow and brown discolorations, there were missing flange bowl caps and exposed rusted screws on toilet base, and the bathroom walls were mainly blue with random pink patched areas. There was one resident who resided in this room. 2. C. Hallway: a. On Room 2's floor near the bed in use, there were worn non-skid floor strips. There was one resident who resided in this room. 3. D. Hallway: a. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. And toilet flange bowl caps were inistalled immediately instable areas have been painted blue to match the rest of the bathroom and painted. The bathroom was deep cleaned and no urine and and the screws removed, patched and painted. The bathroom was deep cleaned and no urine and and no urine and and no urine and no urine strips. a. On Room 2's floor near the bed in use, there were worn non-skid floor strips. There was one resident who resided in this room. 3. D. Hallway: a. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. And toilet flange bowl caps, discolored floor tiles, worn non-skid strips with any concerns addresses/corrected. The facility Administrator or his designee will complete weekly for 4 weeks, then monthly for 6 months. 4.) The results of these tours and any cor				1		, 	Г	
At loilet flange bowl caps were installed immediately The random pink patched areas have been painted blue to match the rest of the bathroom walls were mainly blue with random pink patched areas. There was one resident who resided in this room. A no Room 2's floor near the bed in use, there were worn non-skid floor strips. There was one resident who resided in this room. C C Hallway: A tolet flange bowl caps were installed immediately The random pink patched areas have been painted blue to match the rest of the bathroom C. 2c had the non-skid strips removed D 3 bathroom walls had the screws removed, patched and painted. The bathroom walls had the screws removed, patched and painted. The bathroom was deep cleaned and no urine odor has been identified D 3 bathroom tiles have been replaced 2.) As all residents/rooms have the potential to be affected, the following corrective actions were taken. 3.) A facility wide inspection was completed on 9/13/18 by the facility Administrator to identify any further discolored bathroom call cords, missing toilet flange bowl caps, discolored floor tiles, worn non-skid floor strips. There was one resident who resided in this room. At tolet flange bowl caps were installed immediately The random pink patched areas have been painted blue to match the rest of the bathroom walls had the screws removed, patched and painted. The bathroom was deep cleaned and no urine odor has been identified D 3 bathroom walls had the screws removed, patched and painted. The bathroom was deep cleaned and no urine odor has been identified D 3 bathroom was deep cleaned and no urine odor has been identified. D 3 bathroom was deep cleaned and no urine odor has been identified D 3 bathroom was deep cleaned and no urine odor has been identified D 3 bathroom was deep cleaned and no urine odor has been identified. D 3 bathroom was completed on 9/13/18 by the facility Administrator to identify any further discolored bathroom call cords, missing toilet flange bowl caps, discolored bathroom call c					ID PROVIDER'S PLAN OF CORRECTION OF ACH CORRECTIVE ACTION SHOULD BE			
11:00 a.m11:19 a.m., with the Administrator, the Director of Maintenance, the HousekeepingLaundry Supervisor, and the Regional Consultant, the following was observed: 1. A Hallway: 2. A Room 5's bathroom pull cord had a yellow discoloration, the flange bowl caps were missing on toilet with exposed screws. There was one resident who resided in this room. 3. D Hallway: 2. C Hallway: 3. On Room 2's floor near the bed in use, there were worn non-skid brooms. 3. D Hallway: 4. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and toilet. There were two resident who shared this bathroom. 4. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. 3. D Hallway: 4. On Room 3's bathroom wall, there were four screws sticking out above with coiled at the above was in need of freb tour, indicated the above was in need of freb tour, indicated the above was in need of freb tour, indicated the above was in need of freb tour, indicated the above was in need of freb tour, indicated the above was in need of freb tour, indicated the above was in need of freb tour, indicated the above was in need of frepair or cleaning. 4. 11 tolet flange bowl caps were installed immediately 4. The random pink patched areas have been painted blue to match the rest of the bathroom 5. C Pand the non-skid strips in the screws removed, patched and painted. The bathroom wall be screws removed, patched and painted. The bathroom wall be bathroom was competed and no urine and painted. The bathroom and the bathroom wall the bathroom and the bathroom and the bathroom and tolet. There was one resident who resided in this room. 5. C Hallway: 5. C Hallway: 6. On Room 2's floor near the bed in use, there were worn non-skid strips with any concerns addressess/corrected. 7. D Hallway: 8. At toilet flange bowl caps were mainte		`				CROSS-REFERENCED TO THE APPROPRIA	TE	
Director of Maintenance, the Housekeeping/Laundry Supervisor, and the Regional Consultant, the following was observed: 1. A Hallway: a. Room 5's bathroom pull cord had a yellow discoloration, the flange bowl caps were missing on toilet with exposed screws. There was one resident who resided in this room. b. Room 1's bathroom floor tiles that surrounded the toilet, had yellow and brown discolorations, there were missing flange bowl caps and exposed rusted screws on toilet base, and the bathroom walls were mainly blue with random pink patched areas. There was one resident who resided in this room. 2. C Hallway: a. On Room 2's floor near the bed in use, there were worm non-skid floor strips. There was one resident who resided in this room. 3. D Hallway: a. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. Interview with Administrator at the end of the tour, indicated the above was in need of repair or cleaning. 3.1-19(c) Installed immediately - The random pink patched areas have been painted blue to match the rest of the bathroom - C2 had the non-skid strips removed - D3 bathroom walls had the screws removed, patched and painted. The bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom the follow and brown discolored the following corrective actions were taken. 3.) A facility wide inspection was completed on 9/13/18 by the facility Administrator to identify any further discolored bathroom call cords, missing toilet flange bow (aps, discolored floe) was complete weekly facility Administrator or his designee will complete weekly facility to identify any discolored tile, missing toilet bowl flange caps and any discolored bathroom pull cords. Theses tours and audits will continue wee	IAG			+	IAG			DATE
Housekeeping/Laundry Supervisor, and the Regional Consultant, the following was observed: 1. A Hallway: a. Room 5's bathroom pull cord had a yellow discoloration, the flange bowl caps were missing on toilet with exposed screws. There was one resident who resided in this room. b. Room 1's bathroom floor tiles that surrounded the toilet, had yellow and brown discolorations, there were missing flange bowl caps and exposed rusted screws on toilet base, and the bathroom walls were mainly blue with random pink patched areas. There was one resident who resided in this room. 2. C Hallway: a. On Room 2's floor near the bed in use, there were worn non-skid floor strips. There was one resident who resided in this room. 3. D Hallway: a. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. Interview with Administrator at the end of the tour, indicated the above was in need of repair or cleaning. 3.1-19(c) The random pink patched areas have been planted blue to match the rest of the bathroom - C 2h ad the non-skid strips removed - D3 bathroom walls had the screws removed, patched and painted. The bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was deep cleaned and no urine odor has been identified - D3 bathroom was crews taken. 3. J A facility Administrator to identify any further discolored bathroom call cords, missing toilet flange bowl caps, discolored floored bathroom call cords, missing toilet flange bowl caps, discolo						-	e	
Regional Consultant, the following was observed: 1. A Hallway: a. Room 5's bathroom pull cord had a yellow discoloration, the flange bowl caps were missing on toilet with exposed screws. There was one resident who resided in this room. b. Room 1's bathroom floor tiles that surrounded the toilet, had yellow and brown discolorations, there were missing flange bowl caps and exposed rusted screws on toilet base, and the bathroom walls were mainly blue with random pink patched areas. There was one resident who resided in this room. 2. C Hallway: a. On Room 2's floor near the bed in use, there were worn non-skid floor strips. There was one resident who resided in this room. 3. D Hallway: a. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. Interview with Administrator at the end of the tour, indicated the above was in need of repair or cleaning. 3.1-19(e) a. Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom.						<u> </u>		
1. A Hallway: a. Room 5's bathroom pull cord had a yellow discoloration, the flange bowl caps were missing on tollet with exposed screws. There was one resident who resided in this room. b. Room 1's bathroom floor tiles that surrounded the toilet, had yellow and brown discolorations, there were missing flange bowl caps and exposed rusted screws on toilet base, and the bathroom walls were mainly blue with random pink patched areas. There was one resident who resided in this room. 2. C Hallway: a. On Room 2's floor near the bed in use, there were worn non-skid floor strips. There was one resident who resided in this room. 3. D Hallway: a. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. Interview with Administrator at the end of the tour, indicated the above was in need of repair or cleaning. 3.1-19(e) match the rest of the bathroom - C 2 had the non-skid strips removed nermoved. patched and painted. The bathroom walls had the screws removed, patched and painted. The bathroom was deep cleaned and no urine odor has been identified - D3 bathroom blave been replaced 2.) As all residents/rooms have the potential to be affected, the following corrective actions were taken. 3.) A facility wide inspection was completed on 9/13/18 by the facility to designed on 9/13/18 by the facility to discolored floor tiles, worn non-skid strips with any concerns addresses/corrected. The facility Administrator to identify any concerns addresses/corrected. The facility to identify any discolored the facility to identify any discolored bathroom pull cords. Theses tours and audits will continue weekly for 4 weeks then bi-weekly for 4 weeks then bi-weekly for 6 months. 4.) The results of these tours and any corrective action will be reviewed during the facility's						· · · · · · · · · · · · · · · · · · ·		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155323		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/31/2018		
NAME OF PROVIDER OR SUPPLIER LAKEVIEW VILLAGE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP COD 410 TIOGA RD MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
					ongoing basis for a minimum of six months and the frequency monitoring will be increased or decreased according to finding. The above corrective actions where the completed on or before September 28, 2018.	of gs.	

Event ID: IYWO11 Facility ID: 000216 Page 15 of 15 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet