STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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. This visit included the Investigation of Complaint IN00415824 This visit included a State Residential Licensure Survey. This visit was also in conjunction with the Investigation of Complaint IN00417181. Complaint IN00415824 - Federal deficiencies related to the allegations are cited at F684. Complaint IN00417181 - Federal deficiencies related to the allegations are cited at F684. Survey dates: September 6, 7, 8, 11, and 12 2023. Facility number: 000282 Provider number: 155755 AIM number: 100287520 Census Bed Type: SNF/NF: 91 SNF: 5 Total: 96 Census Payor Type: Medicare: 6 Medicaid: 61 Other: 29 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 13, 2023	F 0000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Golden Years Homestead** does not admit that the deficiencies listed on this report exist, nor does the Facility admit to any statements, findings, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions that form the basis for the deficiencies.	
F 0561 SS=D	483.10(f)(1)-(3)(8) Self-Determination			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven Schaaf	HFA, V.P. Operations	10/03/2023

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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Bldg. 00	§483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.			
	Based on interview and record review, the facility failed to ensure preferences and options for showers and meals were offered and observed for 1 of 2 residents reviewed. (Resident 40) Findings include: During an interview on 9/8/23 at 11:26 AM, Resident 40 indicated the inability to have meal options or to choose shower times and days was	F 0561	The shower schedule of Resident #40 will be adjusted to honor choice of day and time. A meal menu with alternative options available for modified diets will be provided to resident. All cognitively oriented residents will be interviewed to determine if her/his showering schedule is	10/18/2023

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	concerning. Resident 40 indicated they only got whatever meal that was available to them. They did not get to choose other options. Resident 40 further indicated she did not get her showers on Wednesday and Saturdays as she was told she would. When she gripes loud and hard enough she may get a shower on Thursdays when it was conveient for the staff. She preferred shower times to be in the afternoon. Resident 40's record review began on 9/8/23 at 2:19 PM. Diagnoses included, chronic obstructive pulmonary disease with acute exacerbation. Resident 40's BIMS (brief interview mental status) was a 13 out of 15 (cognitively intact). A physician order dated 5/18/23, indicated a diet order of regular with mechanical soft textures. During an interview on 9/8/23 at 1:27 PM, Dietary Cook 6 indicated the facility did not offer a menu or substitutes to residents with therapeutic diets (mechanical soft). They also did not give residents with low BIMS or diagnoses of Dementia/Alzheimer's any choice of meal options. Resident 40's bathing detail from 8/1/23 through 9/8/23 indicated the following: 8/2/23(Wednesday) on 1st shift, a bed bath was given. 8/5/23(Saturday) on 1st shift, a shower was given. There was no indication a shower or bed bath was offered or given on the following dates in August 2023: 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15. 8/16/23(Wednesday) 1st shift, a bed bath was given. 8/19/23(Saturday) 1st shift, a shower was given. There was no indication a shower or bed bath was		acceptable and adjusted if necessary to accommodate preferences. Also, all residents will be provided with the meal menu and available alternate food items. Staff will be educated on the Facility's policy regarding Residents Rights, emphasizing rights regarding freedom of choice. This in-service will be provided by the Director of Nursing/designee. An audit involving a sample of five residents will be conducted by Social Services staff three times a week for four weeks to ensure choice of shower and meal selection are being honored. Then, an audit involving a sample of five residents will be conducted weekly for three months to ensure choice of shower and meal selection are honored. Results of the audits, along with any other documentation, reports and/or observations that may indicate compliance status will be reviewed during the quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	

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	offered or given on the following dates in August 2023: 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, and September 1, 2023. 9/2/23(Saturday) 1st shift, a shower was given. 9/6/23 (Wednesday) 1st shift a shower was given. During an interview on 9/11/23 at 11:51 AM, the Director of Nursing indicated Resident 40's shower times were changed and staff was informed. She indicated the facility did not have a policy for resident choices and the closest thing would be resident rights. A review of facility's Admission Agreement, was provided by the Director of Nursing. The facility's admission agreement indicated..." self-determination...you have the right to and the facility must promote and facilitate self-determination through support of resident choices, including: The right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with your interests, assessments, plan of care and other applicable provisions of this part...You have the right to make choices about aspects of your life in the facility that significant to you...." 3.1-3(u)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' choices. Based on interview and record review the facility failed to ensure physician orders were followed for 2 of 2 residents reviewed. (Resident 9 and Resident 198) Findings include: 1 In an interview on 9/6/23 at 1:04 PM, Resident 9 and her daughter indicated she was confused. Resident 9 indicated the bandage on her leg was from a fall she had at a named facility. Resident 9 was unable to idientify her current facility. Resident 9 was unable to recall why she fell or when. Resident 9 complained of being tired but denied any other complaints. Resident 9's daughter indicated there were times her mother's pain medication was not available when it was to be given. The daughter had no other complaints. In an interview, on 9/11/23 at 1:31PM, RN 4 indicated she removed (2) 25mcg Fentanyl patches and a 100mcg Fentanyl patch from Resident 9 and replaced them with a 100mcg Fentanyl patch. RN 4 indicated there was a onetime order for the (2) 25mcg patches until the 100mcg patches were received from the facility pharmacy. Residents 9's record review began on 9/11/23 at 2:22PM, her diagnoses included chronic pain, osteoarthritis, and polyneuropathy. Resident 9's Current Quarterly MDS (Minimum Data Set) assessment on 8/24/23, Section C for Cognitive Patterns indicated her BIMS (Brief Interview of Mental Status) was a 12 showing mild cognitive decline. Section N of Resident 9's MDS indicated	F 0684	The fentanyl and norco medication will be administered to Resident #9 according to the physician's orders. Resident #198 expired. The physicians' orders and medication administration records of all residents receiving narcotic medications will be reviewed by nursing administration to ensure compliance with the orders. The Facility will change institutional pharmacy providers to achieve optimal service regarding timely medication delivery and availability of emergency drugs. An audit will be conducted by the Director of Nursing/designee three times a week for four weeks to verify the availability of narcotic medication onsite and timely administration of narcotic medications. Then, an audit will be conducted weekly for three months to verify the availability of narcotic medication onsite and timely administration of narcotic medications. Results of the audits, along with any other documentation, reports and/or observations that my indicate compliance status will be reviewed during the quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	10/18/2023

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	she received Opioid medication for 7 of the 7 days reviewed. Resident 9's history and physical dated September 6, 2023, listing current medications did not include Fentanyl patch. Subsequent history and physicals did include Fentanyl patch. The current order for the Fentanyl patch was dated January of 2023. Resident 9's MAR (Medication Administration Record), narcotic count sheets, and physician orders indicated medications were not given as ordered. The last 3 months of physician orders were reviewed. Orders for narcotic medications were as follows: Norco 5-325mg tablet four times a day start date 8/8/23 stopped 9/10/23. Fentanyl Patch check placement every shift start date 1/28/23. Fentanyl 100mcg/hr. transdermal path apply 1 patch topically every 72 hours start date 1/28/23. From September 1 through September 10th the MARs documented Fentanyl patch was administered and placement was checked as indicated by staff initials as follows: 9/1/23 11am Fentanyl 100mcg patch med not available supervisor called pharmacy to resolve the issue. The note indicated the facility had not heard from the pharmacy that day 9/4/23 11am Fentanyl 100mcg patch med not available. The patches had been delivered. The staff member removed the old patch, and the ADON (Assistant Director of Nursing) was notified. 9/10/23 11am Fentanyl 100mcg patch med not available supervisor notified.			

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	9/10/23 11am Norco 5-325mg med not available 9/10/23 4pm Norco 5-325mg med not available 9/10/23 9pm Norco 5-325mg med not available Resident 9's controlled substance count sheet indicated no Norco was removed for the 9/6/23 bedtime dose. The missed dose was not documented in Resident 9's chart. Resident 9's controlled substance count sheets for Fentanyl patches indicated there were gaps from 8/23/23 to 8/29/23 and from 8/29/23 to 9/5/23. There was documentation on the September 2023 MAR and count sheet to support the Fentanyl patch administration was on 9/5/23 and 9/7/23; 48 hours not 72 hours as prescribed. On 9/12/23 at 9:18AM the DON provided a onetime order for (2) 25mcg Fentanyl patches for Resident 9 due to the medication available in emergency medication supply. The DON further provided a hand written note from a facility staff to indicate she placed them on Resident 9 on 9/10/23 at 12:05AM there was no physician's order, no MAR, no progress note, and no narcotic sign off sheet to indicate Resident 9 received the medication. In an interview on 9/12/23 at 9:18AM the DON indicated the problem was the QMAs (Qualified Medication Assistant) were prohibited from documenting. The DON indicated they had a backup local pharmacy. The DON indicated the facility stopped their contract with the current facility pharmacy with a required 90 days' notice. The DON indicated in this case the problem was not the just the pharmacy lack of timeliness but also the doctor was on vacation. 2) Resident 198's Record review began on 9/11/23			

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	at 2:33 PM. His diagnoses included dementia and end of life care. Resident 198's orders for the last 60 days were reviewed. The orders included Oxycodone 20mg/ml give 0.5ml by mouth every 2 hours as needed for break through pain start date 8/23/23; Fentanyl 25mcg 1 patch every 3 days start date 8/20/23; Oxycodone 20mg/ml give 0.5ml by mouth every 12 hours start date 8/13/23; Apply Fentanyl patch to area of hairless, clean skin out of reach of resident and cover with transparent dressing start date 8/19/23. The orders did not match the documented count sheet orders nor the MAR. Resident 198's MARs dated August 2023 indicated to apply Fentanyl patch to area of hairless clean skin out of resident reach was documented on 8/3/23, 8/6/23; 8/9/23; 8/12/23; 8/15/23; 8/18/23; and 8/21/23. The application did not match the administration record or the controlled count record sheet. Resident 198's controlled substance record dated August 2023 documented the Fentanyl patch was signed out on 8/5/23; 8/6/23; 8/8/23; 8/11/23; 8/11/23; 8/15/23; 8/18/23; 8/20/23; and 8/23/23. The controlled substance sign out sheet did not indicate the patch was administered or removed from stock every 3 days as ordered. Resident 198's MARs dated August 2023 indicated Fentanyl 25mcg/hr. transdermal patch was administered on 8/5/23; 8/8/23; and 8/20/23. The period of 8/8/23 to 8/20/23 was not 72 hours as ordered. At the end of the August 2023 MAR documentation there was one documentation of Fentanyl patch on 8/6/23 placed on the right back			

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	shoulder. One Fentanyl patch on 8/21/23 1:04 PM was a new patch administered 8/20/23, due to the one admiinistered on 8/18/23 was missing. In an interview on 9/12/23 at 11:18AM, the DON indicated Resident 9's last 60 days of medication requisitions was retrieved from trash cans. Resident 198's medication requisitions were unavailable. The DON indicated she was unaware others were discarding the requisitions after receiving the supply from pharmacy. No policy or further information was available by time of exit. This Federal Citation is related to Complaint IN00415824 and IN00417181. 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to ensure safety for 1 of 5 people reviewed. (Resident 9) During an observation and interview with Resident 9 on 9/6/23 at 1:04 PM she appeared with a white criss cross bandage wrapped around leg. She indicated she fell at a facility and referred to it	F 0689	An updated elopement risk assessment of Resident #9 will be completed and the care plan will be updated accordingly. Elopement risk assessments will be completed on all current residents and newly admitted	10/18/2023

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	as some place else. She was unable to indicate when or how she fell. She was unable to tell what she had for breakfast or lunch. During an interview on 9/11/23 at 1:08PM, Resident 9 did not remember going outside at all. Resident 9 indicated she "blacks out" at times. She was further able to indicate the memory loss was off and on. Resident 9 complained of being tired. During an interview on 9/11/23 at 1:11PM, Resident 9's daughter indicated Resident 9 had began to wander and more confused in the last two months. The daughter was unable to indicate where the Resident 9 was found or how long she was missing. The daughter indicated she got a phone call to explain Resident 9 eloped and refused to come in for a period but was safe. Resident 9's daughter further indicated she was glad they did find her mother as she would not have been able to get back into the building because of the needed code. During an interview on 9/11/23 at 1:31PM, RN (Registered Nurse) 4 indicated Resident 9 was looking out the door near room 18 on 9/7/23 around lunch time, when RN 4 went to another unit to give meds. RN 4 indicated a CNA (Certified Nursing Assistant) saw Resident 9 through the window near room 1 outside by herself. RN 4 immediately sent the CNA out to be with Resident 9 and alerted social services to go out and assess. RN 4 indicated Resident 9 refused to return to the facility. She was upset, wanted to leave, and she was going home. Resident 9 consented to returning to the building with RN 4 after a stroll. Upon returning, RN 4 alerted staff, filled out a social service report (on paper), and started 15min checks. RN 4 indicated she told everyone. RN 4		residents. The care plans will be updated if indicated. Staff will be educated on Facility's Resident Elopement policy. This in-service will be provided by the Director of Nursing/designee. An audit will be conducted three times a week for four weeks of the medical charts of residents in the non-secure areas of Facility who have been identified as being at-risk for elopement to ensure the effectiveness of elopement care planning. Then, an audit will be conducted weekly for three months of the medical charts of residents in the non-secure areas of Facility who have been identified as being at-risk for elopement to ensure the effectiveness of elopement care planning. Results of the audits, along with any other documentation, reports and/or observations that may indicate compliance status will be reviewed during the quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	

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	admitted to forgetting to put in a progress note or to update the CNA assignment sheet with the information. RN 4 indicated Resident 9 had attempted to elope a couple of times in the past but would always come right back without hesitation. RN 4 indicated Resident 9 had increased confusion and looking for her husband who has passed. Resident 9's record review began on 9/11/23 at 2:22PM, indicated diagnoses included history of falls, major depression, glaucoma, and dementia. Resident 9's current Quarterly MDS (Minimum Data Set) assessment on 8/24/23, Section C for Cognitive Patterns indicated her BIMS (Brief Interview of Mental Status) was a 12 showing some moderate cognitive decline. Resident 9's history and physical from 8/15/23 indicated she has been becoming more confused and had an increase in wandering than she usually had despite medication reductions. On the 8/22/23 note, the doctor indicated the confusion continued. Resident 9's most recent elopement risk completed 7/13/23 indicated the facility assumed no elopement risk potential. The assessment had not been updated to indicate the changes in Resident 9. The mental stability assessment was marked as alert and oriented, but the resident was not alert and oriented as evidenced by an inablility to indicate where she was or what she had eaten. The elopement attempts section was not marked, but there were recent attemps with success. The emotional status assessment indicated the resident was happy, but Resident 9 was not happy with placement as evidenced by wanting to leave and not wanting to come back in. The			

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	dementia or mental disorders portion was marked as 1, no dementia or mental disorders. The elopement number of days without attempts assessment was marked as greater than 120, but there were attempts with in 30 days. Resident 9 was not care planned for elopement or wandering. Resident 9's most recent care plan 9/5/23 did not address her elopment attempts or give the staff any interventions to attempt to prevent elopement. No policy or further information was provided by time of exit. 3.1-45(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review the facility failed to provide adequate pain management for 1 of 3 residents reviewed. (Resident 13). Findings include: During an observation and interview on 9/6/23 at 9:52AM, Resident 13 was lying in bed clutching one hand inside of the other. Resident 13 indicated he was always in pain. Resident was aware of his diagnoses and medications. Resident 13 indicated he did not receive any non-pharmaceutical interventions for his pain	F 0697	A pain assessment will be completed and a pain management consultation will be offered to Resident #13. Also, an assessment of non-pharmacological interventions will be completed for Resident #13 and the care plan will be updated accordingly. All residents with PRN pain medication orders will receive a pain assessment and care plans reviewed for non-pharmacological	10/18/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	prior to as needed narcotic pain medication. Resident 13 indicated he tried not to take the medication on days he did not have therapy. Resident13 rated his pain during this interview a 7 with the majority being in his hands and back. Resident 13 indicated when he was home and able to care for himself running his hands under warm water helped loosen up the joints and greatly improved the pain and mobility. During an observation and interview with Resident 13, on 9/7/23 at 11:18 AM, in his room sitting in a wheelchair next to his bed. During this interview he rated his pain an 8. He described the pain as crunching and stabbing. Resident 13 indicated he last had pain medication at 6am. Resident 13 indicated the lifts were not made for people with curved spines. Resident 13 indicated getting in and out of bed were the worst part of his day. Resident 13 indicated his back spasms most times. Resident 13's record review, began on 9/7/23 at 12:01PM, his diagnoses included polyosteoarthritis, hypertrophic osteoarthropathy, anxiety, and chronic pain. Resident 13's current MDS (Minimum Data Set) section C: BIMS (Brief Interview of Mental Status) assessment score was a 15. A score of 15 indicated no cognitive decline. Section N: Medications indicated Resident 13 received an opioid medication 7 of 7 days in review period. Resident 13 had an order for hydrocodone-Acetaminophen 5-325mg by mouth twice daily start date 5/25/23 and hydrocodone-Acetaminophen 5-325mg 1 tablet every 6 hours as needed for chronic pain.		interventions. Care plans will be updated if indicated. The medication administration protocol will be modified to prompt nursing staff to implement and document non-pharmacological interventions before administering PRN pain medications. Nursing staff will be educated on the modification to the medication administration protocol. This in-service will be provided by the Director of Nursing/designee. An audit will be conducted by the DoN/designee three times a week for four weeks to ensure compliance with non-pharmacological interventions related to the administration of PRN pain medications. Then, an audit will be conducted weekly for three months to ensure compliance with non-pharmacological interventions related to the administration of PRN pain medications. Results of the audits, along with any other documentation, reports and/or observations will be reviewed during the quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	

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	From September 1st through September 7th Resident 13 received hydrocodone-Acetaminophen 5-325mg as needed three times. On 9/3/23 at 11:27AM, on 9/4/24 at 12:00PM, and 9/7/23 at 12:04PM. There was no documented assessments of pain intensity, type, place, or effectiveness of the medication. There was no documentation of non-pharmacological interventions attempted prior to as needed pain medication being administered. Resident 13's care plan did not indicate any non-pharmacological interventions. The care plan indicated an assessment regarding the cause of his pain and the effectiveness of the medication was yet to be performed. A policy titled, "Pain Management" first effect date 5/2019 with most recent revision date 10/24/22, was provided by the DON (Director of Nursing) on 9/8/23 at 2:06PM. The policy indicated, "Pain assessment...2. e. Identify key characteristics of the pain. Duration. Frequency. Location. Timing. Pattern. Radiation. F. obtaining descriptors of the pain (stabbing, aching, pressure, spasms). G. identifying activities, resident care or treatment that precipitate or exacerbate pain and those that reduce or relieve pain. H. impact of pain on quality of life. I. current prescribed medications. J. Resident's goals for pain management. Pain Management and Treatment. 1. Based upon evaluation, the facility in collaboration with the attending physician/prescriber, the resident will develop, implement, monitor, and revise as necessary interventions to prevent or manage individual resident's pain. 6. non-pharmacological			

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	interventions will include but are not limited to: a. environmental comfort measure b. loosening any constrictive bandage c. applying splint/pillows ... ... 3.1-37(a)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on interview and record review the facility failed to ensure residents receive culturally competent, trauma-informed care for 1 of 1 residents reviewed (Resident 49). Findings include: Resident 49's record was reviewed on 09/06/23 at 11:44 AM. Diagnoses included cognitive communication deficit, major depressive disorder, and history of falling. There was no PTSD (Post Traumatic Stress Disorder) diagnosis present at time of review. A review of Resident 49's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). There were no care plans for PTSD. A review of progress notes dated 08/01/2023 at	F 0699	The trauma-informed assessment and protocol will be conducted on Resident #49. The care plan will be updated accordingly. The trauma-informed assessment and protocol will be conducted on all current residents and newly admitted residents. Care plans will be updated if indicated. Social Services staff will be educated on Facility's Trauma Informed Care Policy. This in-service will be provided by the Director of Nursing/designee. An audit will be conducted by Social Services/designee three times a week for four weeks to assure adequate progress is being made with completing the	10/18/2023

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	2:40 PM indicated Resident 49 informed the Nurse Practitioner (NP) of recent PTSD flare ups caused by loud noises, scaring Resident 49. In an interview on 09/08/23 at 11:53 AM, Resident 49 indicated they had not been depressed recently, but loud noises have been more irritating, upsetting and recalling PTSD situations. Resident 49 indicated they had spoken to the NP regarding these concerns. A current policy dated 03/01/2023 provided by the Director of Nursing indicated the facility should provide care and services delivered using multiple approaches to address the needs of trauma survivors.		trauma-informed assessment and protocol on current and newly admitted residents. Then, an audit will be conducted weekly for three months to assure adequate progress is being made with completing the trauma-informed assessment and protocol on current and newly admitted residents. Results of the audits, along with any other documentation, reports and/or observations that may indicate compliance status will be reviewed during the quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on interview, observation, and record review the facility failed to ensure to maintain a sanitary kitchen for 3 of 3 observations. Findings include: 1. In an interview on 9/6/23 at 9:47 AM, the Dietary Manager (DM) indicated the kitchen had a low temperature dishwasher. During an observation on 9/6/23 at 9:47 AM, the dishwasher wash was 80 F and the rinse was 85 F. During an observation on 9/6/23 at 1:06 PM, the dishwasher wash was 82 F and the rinse was 82 F. In an interview on 9/6/23 at 1:06 PM, the DM indicated this was a normal temperature for the dishwasher. An email, dated 9/6/23, by the dishwasher servicing company was provided by the DM at 1:06 PM. The email indicated the wash temperature should be 120 F and the rinse should be 50-100 parts per million for chlorine to properly sanitize. A policy was requested from the Director of Nursing (DON) on 9/6/23 at 1:28 PM. The facility did not provide a policy by the survey exit. 3.1-21(i)(3)	F 0812	The low-temperature dish machine will be corrected to ensure a wash temperature of 120ºF and hypochlorite sanitization of at least 50 PPM are consistently achieved. The Director of Culinary and the Director of Facility Maintenance will be educated on Facility's Dish Machine Temperature policy. This in-service will be provided by the Administrator. Culinary staff will be educated on Facility's Dish machine Temperature policy. This in-service will be provided by the Director of Culinary. An audit will be conducted by Director of Culinary/designee three times a week for four weeks to ensure documentation of dish washing machine wash cycle temperatures and hypochlorite sanitation levels comply with facility policy. Then, an audit will be conducted weekly for three months to ensure documentation of dish washing machine wash cycle temperatures and hypochlorite sanitation levels comply with facility policy. Results of the audits, along with any other documentation, reports and/or observations that may indicate compliance status will be	10/18/2023

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			reviewed during the quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	
F 0814 SS=D Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation and interview the facility failed to ensure garbage and refuse were contained inside the dumpster for 2 of 3 observations. Findings include: During an observation on 9/6/23 at 9:56 AM with the Dietary Manager, there were 2 bags of trash, piles of used gloves, and 2 empty cardboard containers on the ground around the dumpster. In an interview on 9/6/23 at 9:56 AM, the Dietary Manager indicated the maintenance department maintained the dumpster. The Dietary Manager indicated there should not be trash lying around the dumpster. The Dietary Manager also indicated the trash present appeared as it had been on the ground for awhile. In an interview on 9/6/23 at 10:04 AM, the Maintenance Director indicated the maintenance department maintained the cleanliness of the dumpster. The Maintenance Director indicated there should not be trash lying around the dumpster. The Maintenance Director also indicated the trash appeared as it had been on the ground for a long time. In an interview on 9/6/23 at 1:28 PM, the Director of Nursing (DON) indicated the dumpster should	F 0814	Facility management will create a policy addressing waste dumpster inspection and maintenance. The Director Facility Maintenance and Director of Culinary will be educated on Facility's policy addressing waste dumpster inspection and maintenance. This in-service will be provided by the Administrator. Maintenance and Culinary staff will be educated on Facility's policy addressing waste dumpster inspection and maintenance. This in-service will be provided by the Director of Facility Maintenance. An audit will be conducted by Director of Facility Maintenance/designee three times a week for four weeks to ensure compliance with dumpster inspection/maintenance and proper disposal of waste/garbage. Then, an audit will be conducted weekly for three months to ensure compliance with dumpster inspection/maintenance and proper disposal of waste/garbage. Results of the audits, along with	10/18/2023

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	not have trash or debris around it. The DON indicated the facility did not have a policy regarding the dumpster maintenance. 3.1-21(i)(5)		any other documentation, reports and/or observations that may indicate compliance status will be reviewed during the quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.This visit included the Investigation of Complaint IN00415824 This visit was also in conjunction with the Investigation of Complaint IN00417181. Survey dates: September 8, 2023 Facility number: 000282 Residential Census: 40 Golden Years Homestead was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed September 13, 2023.	R 0000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Golden Years Homestead** does not admit that the deficiencies listed on this report exist, nor does the Facility admit to any statements, findings, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, and conclusions that form the basis for the deficiencies.	