| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155755 | A. BUILDING 00<br>B. WING | 09/23/2024 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included an Investigation of Complaints IN00440828, IN00442467, IN00443361.<br><br>Complaint IN00440828- Unsubstantiated due to lack of evidence.<br><br>Complaint IN00442467-Unsubstantiated due to lack of evidence.<br><br>Complaint IN00443361- Substantiated cited F600<br><br>Survey dates: September 17, 18, 19, 20, and 23, 2024.<br><br>Facility number:000282<br>Provider number: 155755<br>AIM number: 100287520<br><br>Census Bed Type:<br>SNF/NF: 95<br>SNF: 3<br>Residential: 42<br>Total: 140<br><br>Census Payor Type:<br>Medicaid: 62<br>Medicare: 3<br>Other: 27<br>Total: 98<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed September 25, 2024 | 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 for the basis for the deficiencies. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Steven Schaaf | HFA, V.P. Operations | 10/04/2024 |

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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| F 0600 SS=D Bldg. 00 | 483.12(a)(1)<br>Free from Abuse and Neglect<br><br>Based on observation, interview, and record review the facility failed to ensure 1 of 5 residents reviewed were free of abuse. (Resident 26).<br><br>Findings include.<br><br>Resident 26's record was reviewed 9/17/24 at 2:18PM. Resident 26's diagnoses included dementia, depression, and muscle weakness.<br><br>A Minimal Data Set (MDS) assessment, dated 8/21/24, indicated Resident 26's Brief Interview for Mental Status score (BIMS ) was 3. A score of 3 indicated severe cognitive decline. Section E of MDS indicated Resident 26 had no behavioral symptoms of aggression. Resident 26 was continent of bowel and used a catheter due to urine retention.<br><br>Resident 26's care plan, dated 9/17/24, indicated he had cognitive loss. Interventions were to allow plenty of time for care, do not rush or push, do not show impatience.<br><br>Resident 26's care plan, dated 9/17/24, had a problem of argumentative behavior and becoming agitated easily by others. Interventions were to please intervene as needed to ensure safety and the safety of others, please talk with resident in calm manner; do not give directions, do not argue.<br><br>Resident 26's September 2024 behavior sheet was reviewed. There were 48 documentations missing. There were 3 behaviors being monitored. Anxiety, aggression, and sleep disturbance per shift. Of the 108 documented there were 4 behaviors noted. 2 on 9/16/24 aggression and anxiety and 2 on | F 0600 | The incident involving alleged physical abuse by QMA 6 and Resident 26 was reported to ISDH and an investigation was conducted. Resident 26 was assessed for injury and the care plan was updated as indicated. The Facility's investigation substantiated physical abuse and QMA 6 was subsequently released from employment with Facility.<br>Alert and oriented residents will be interviewed to determine if any employee of Facility has inflicted physical harm upon them. For any resident who indicates an employee has caused physical harm, ISDH/family will be notified, and a full investigation will be conducted including an assessment of resident and updating of the care plan. For residents who cannot be interviewed, body assessments will be conducted on designated bathing days to observe for signs of physical abuse. Any observations that lead to a suspicion of physical abuse will be considered an allegation of physical abuse and likewise reported to ISDH/family and followed up with a full investigation including an assessment of resident and updating of the care plan. | 10/17/2024 |

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| | 9/18/24 aggression and anxiety. The behavior on 9/16/24 was documented as 1st shift. The intervention was documented as redirection and as effective. The behaviors on 9/18/24 were also recorded as 1st shift. The intervention was redirection. The outcome was zero.<br><br>Resident 26 was observed on 9/17/24 at approximately 10AM, playing bingo in the main activity room. He was sitting at a table with others calmly. Resident 26 was observed on 9/18/24 at approximately noon eating a meal at table with peers talking quietly, no distress noted.<br><br>During an observation, on 9/19/24 at 12:17 PM, the video taped footage of an incident between Resident 26 and Qualified Medication Assistant (QMA) 6 on 9/16/24 at 6:18AM was viewed. The video tape showed Resident 26 and QMA 6 at a med cart near the corner of a hall. Talking for several minutes. The resident had no hand gestures, pacing, or other signs of agitation noted. QMA 6 had a relaxed posture. QMA 6 pushed Resident 26 against the wall. Resident 26 walks away and comes back with something in his hand. He approaches QMA 6, they again have a brief discussion. Resident 26 reaches towards her and begins to walk away. QMA 6 then perused Resident 26 reaching around his body and grabbed his glasses from his face while he was in motion. Resident 26 immediately turns back around and begins another discussion. The video then goes to another view of the hall and shows Resident 26 with an arm on QMA 6 and another reaching for something. At the time QMA 6 was up against the wall. QMA 6 then pushes Resident 26 across the entire width of the hall into the opposite wall. Resident 26 falls down the wall onto the ground. Resident 26 loses his shoe during this interaction. QMA then walks away | | Staff assigned to the Memory Care Neighborhoods will receive inservice training on Facility's policy and procedure titled, "Abuse, Neglect and Exploitation." This inservice will be provided by DoN/designee. The training will include demonstrations to counteract physical aggression exhibited by a resident and reviews of each resident's individual care plan related to physical aggression, as applicable.<br>A sample of five alert and oriented residents will be interviewed weekly for four weeks to determine if any employee has caused physical harm onto them. Also, skin sheets of non-interviewable residents will be audited weekly for four weeks to determine if any skin conditions indicate possible physical abuse. Then, the audits will be completed weekly for three months. The audits will be completed by nursing leadership. Results of the audits, along with any other documentation, reports and/or observations that may indicate compliance status will be reviewed by the Quality Assurance committee during quarterly meetings for a period of one year to ensure substantial compliance is maintained. | |

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| | leaving Resident 26 on the ground alone, she looks back states something and walks around the corner. The incident took place on a secured memory care unit. Throughout the video there was another staff member going in and out of rooms on the unit. The other staff member never showed any alarm. There was another resident present who was not interviewable and was unharmed.<br><br>In an interview, on 9/19/24 at 12:17 PM, the Director of Nursing (DON ), indicated her reaction as disbelief and shock. The DON described the footage as QMA 6 pushed Resident 26 against the wall. The DON presented statements from QMA 6 and other staff as part of her investigation of incident.<br><br>In an interview, on 9/20/24 at 10:06AM, HR (Human Resources) indicated there was a 3.5 min gap missing in the recordings. The view of cameras changed from Hickory Dining to Hickory Living cameras. There was no visualization of QMA 6 or Resident 26 from 6:14:25AM to 6:18:12AM on 6/16/24. The cameras were meant to pick up any motion and record. The HR director indicated the Memory Care Manager (MCM) came to her around 9:30AM and asked to see the videos. Notification was then made to the DON, the Administrator, family, and the Physician<br><br>An observation of the Hickory Living video, on 9/20/24 at 10:06AM, indicated after the incident, Resident 26 laid on the floor for 5 seconds before gathering his shoe and getting himself up from the floor. .<br><br>A fall statement, dated 9/16/24, indicated Resident 26 was pulling QMA 6's hair and grabbing her. She tripped over own shoes and fell up against | | | |

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| | wall down to floor while being abused by the resident<br><br>A statement from QMA 6, dated 9/16/24 at 3:10PM, indicated Resident 26 indicated he was going to walk with her. Resident 26 accused QMA 6 of waking him up. She reminded him when she came to him room, he was on the toilet soiled. He then reminded her she said she would come back, and she did not. He called her an idiot and then spelled it out "IDOT (sic)". QMA 6 then explained that idiot had 2 I's. He asked for her name. she told him. He returned with a pad of paper and asked her to write it down. He was going to report her. QMA 6 explained she already told him... QMA 6 refused to write her name. Resident 26 grabbed QMA 6's badge. QMA 6 attempted to grab it back. QMA 6 then quickly slid Resident 26's glasses off. He demanded his glasses back. QMA said for the badge. Resident 26 had QMA 6 up against the wall. QMA 6 asked Resident 26 to let her go. Resident 26 refused. An unidentified resident came closer, QMA 6 wrote in her statement a distraction was possible and she pushed Resident 26.<br><br>An MCM statement indicated upon arriving for work on 9/16/24, she was met by QMA 6 who requested her to get the badge from Resident 26. The MCM went to Resident 26, he indicated he turned it in downtown. After he felt around for it, he gave it easily to the MCM who gave Resident 26 his glasses. Resident 26 stated, "oh there those are".<br><br>The DON's statement indicated Resident 26 complained of back pain and was given an Xray to rule out any injuries. He also fell a few days prior to the incident, during an activity and had minor complaints then as well. DON indicated | | | |

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| | disciplinary action was taken for QMA 6.<br><br>In an interview, , the Maintenance Supervisor indicated the cameras were set to record on movement to allow for longer saving time. Less recording increased ability to save for more days. Maintenance measured the width of the hallway where incident occurred at 7ft. 8 inches. There were no other signs of struggle. No holes in the wall, and no scratches at time of incident to Maintenances knowledge.<br><br>During an observation, on 9/20/24 at 12:24PM, there were no pictures, fire extinguishers, doors, or other items attached to the walls during observation.<br><br>In an interview, on 9/23/24 at 9:38A , the Restorative Aid indicated facility training related to abuse indicated staff was never to put hands on a resident.The abuse training module was on the computer. The Restorative Aid indicated the facility did not do any simulated trainings to her knowledge.<br><br>A policy and procedure titled, "Abuse, Neglect, Exploitation Policy" dated 9/20/22 last updated 4/23/24 was obtained from DON on 9/23/24 at 9:40AM. The policy indicated..." Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.. It can include verbal abuse, sexual abuse, physical abuse, and mental abuse ....<br><br>This Federal Citation is realted to complaint IN00443361.<br><br>3.1-27(a) | | | |

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| F 0699 SS=D Bldg. 00 | 483.25(m)<br>Trauma Informed Care<br><br>Based on observation, interview, and record review the facility failed to ensure interventions were implemented to prevent feelings of fear for 1 of 2 residents reviewed. (Resident 3)<br><br>Findings include:<br><br>In an interview, on 9/17/24 at 11:09AM, She indicated she had been overwhelmed since her husband's passing in May 2024. Resident 3 pointed to several boxes against the wall across from her bed of memorabilia she felt responsible to sort and disperse to family members. Resident 3 explained her diagnosis of PTSD realted to sexual, verbal, and physical abuse as a child. Resident 3 indicated the only times she was triggered in the facility was when a peer (Resident 85) was coming into her room uninvited especially at night. Resident 3 described a male peer coming into her room sometimes making it to the foot of her bed before she would see him or feel him looking at her. Resident 3 reported she would be the one to alert staff to his continued unwanted presence in her room, and he would be redirected back to his room. After several incidents, more than 5 times of redirecting peer back to his room, the Resident 85 was moved to another room and the visits stopped. Resident 3 indicated no other solution was given to her or offered. The facility placed no stop signs on her door, no net was placed to deter the peer. Resident 3 requested to be able to lock her door and was told that was not allowed for safety concerns. Resident 3 indicated she felt safe at this time. Resident 3 indicated Resident 85 never got far enough to do anything physically to her but she felt very anxious and extremely uncomfortable in the situation. | F 0699 | An updated assessment for trauma-informed care will be completed for Resident 3. A trauma specific are plan addressing problems with trauma will be developed and implemented.<br>The medical records of all residents will be reviewed for indications of trauma care needs. Any resident found to have trauma care needs will be assessed according to Facility policy titled, “Trauma informed Care” and her/his care plan will be updated.<br>Social Services staff will be educated on Facility policy titled, “Trauma informed Care.” This inservice will be provided by DoN/designee.<br>An audit will be completed by Social Services staff three times a week for four weeks to assure adequate progress is being made with completing the trauma-informed assessment and protocol on current and newly admitted residents. Then, an audit will be completed 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 | 10/17/2024 |

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| | During an observation, on 9/17/24 at 11:09AM, Resident 3 was observed to be tearful.<br><br>Resident 3's record was reviewed on 9/18/24 at 10:59AM. Diagnoses included anxiety, depression, and post traumatic stress disorder.<br><br>A Minimum Data Set (MDS) assessment, dated 7/3/24, indicated Brief Interview of Mental Status (BIMS ) score was 15. A score of 15 indicated no cognitive decline. Section D for mood indicated Resident 3 had difficult falling, staying, or sleeping too much nearly every day. Section E for behaviors indicated Resident 3 had no behaviors.<br><br>Monthly Behavior Monitoring Flowsheets were reviewed, dated August 2024. No incidents of behaviors were recorded. The behaviors being monitored were mood disorders, depression, and insomnia. August 23 was without documentation.<br><br>Monthly Behavior Monitoring Flowsheets were reviewed, dated September 2024. No incidents of behaviors were recorded. The behaviors being monitored were mood disorders, depression, and insomnia.<br><br>Resident 3's Brief Trauma Questionaire was not dated. The DON dated it for the date of admission. The DON indicated no other trauma assessment was performed. In the questionnaire it was identified Resident 3 had trauma related to the following:<br>Accident were she was seriously injured, a life threatening illness and cancer, before age 18 was physically punished and would feel threatened or in danger. and was pressured into having unwanted sexual contact and would feel in danger. | | observations that may indicate compliance status will be reviewed by the Quality Assurance committee during quarterly meetings for a period of one year to ensure substantial compliance is maintained. | |

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A Care Plan, dated 6/3/24, indicated a problem of mood state, signs of depression, diagnoses of anxiety, depression, personality disorder, PTSD (post traumatic stress disorder). The goal was the resident would like her mood to improve. Interventions were as follows: administer medications as ordered, schedule psych eval and follow any treatment recommendations, and provide an opportunity to vent issues. There was no trauma specific problem in the care plan. No goal made for trauma needs. There were no interventions or triggers identified.

A care plan, dated 9/20/24, included a problem of trauma. The problem indicated a potential for mood disturbance related to history of childhood trauma- moved on and healed from traumatic events in their life and denies having any triggers for remininscing.
The goal indicated the resident would be able to verbalize if they become triggered and remembering past events through next review.
The interventions were as follows:
Observe for non verbal cues regarding traumatic events
Offer resident safe place to vent feelings
Encourage resident to participate in activities of enjoyments such as
Offer psych services if willing to participate

A physician note, dated 8/26/24, indicated Resident 3 had an acute complaint of a male peer coming into her room. Resident 3 was given PRN hydroxyzine every 8hrs and details were discussed with social services.

A policy and procedure titled, "Trauma Informed Care" dated 11/2019, last updated 8/21/2024 was provided by DON on 9/19/24 at 2:16PM. The

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| | policy indicated...provide care and services account for experiences and preferences, and address the needs of trauma survivors by minimizing triggors and/or retraumatization...d. physical, sexual, mental, and/or emotional abuse (past or present). i. Traumatic life events (death of a loved one, personal illness, etc)....a. safety. Ensuring residents have a sense of emotional and physical safety. d. empowerment. voice. and choice. 7. Trauma specific care plan will interventions will recognize the interrelationship between trauma and symptoms of trauma. | | | |
| F 0761 SS=E Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br><br>Based on observation, interview and record review, the facility failed to ensure medications were dated when opened, and destroyed when expired in 2 of 4 medication carts.<br><br>Findings include:<br><br>During an observation, on 9/17/24 at 1:36 PM, with License Practical Nurse (LPN) 4 on the D hall medication cart, Trelegy 100/ 62.5, inhaler was without a box and no open date for Resident 47. LPN 4 indicated medication should not be in the cart without the date.<br><br>During an observation on 9/17/24 at 1:50 PM, with Qualified Medication Aide (QMA) 5 on C hall medication cart, there was an open bottle of Nystatin Sus 100 mg with no open date for Resident 27.<br><br>On the second medication Cart on C hall with QMA 5, was a bottle of Lidoncaine Sol 2% oral with no open date for Resident 25. In the same medication cart, was the medication Insulin Lispro | F 0761 | The undated and/or expired medications prescribed to Residents 47, 27, 25, 37 and 13 have been removed from the medication carts and destroyed. An updated physician's order for the Nystatis Sus 100 will be obtained for Resident 27. The physician/responsible party of Resident 37 will be notified that the insulin administered on September 17, 2024 had expired on September 16, 2024. The physician/responsible part of Resident 13 will be notified that the insulin administered on September 15, 16 and 17 had expired on September 14, 2024. All medication carts and medication storage rooms/areas will be fully inspected for the presence of improperly labeled/expired medications. Any improperly labeled/expired | 10/17/2024 |

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| | INJ 100 U with an open date of 8/18/24 and an expiration date of 9/16/24 for Resident 37. In the same drawer there was a medication of Lantus INJ 100 U with an open date of 8/16/24 and expiration date of 9/14/24 for Resident 13.<br><br>1. A record review for Resident 47 on 9/18/24 at 9:05 AM. Diagnoses included, Chronic Pulmonary Disease unspecified.<br><br>A review of the Physician orders indicated to give Trelegy Ellipta 100 mcg (microgram)-62.5 mcg- 25 mcg powder for inhalation ( Fluticasone-umecclidin-vilanter) inhale 1 puff daily at noon, rinse mouth with water after use- 1 puff inhalation every day for chronic pulmonary disease with a start date of 8/22/24.<br><br>A review of the medication administration record (MAR), dated September 2024, indicated Trelegy Ellipta was given on the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17. There was no open date for this medication.<br><br>2. A record review of Resident 27, on 9/18/24 at 9:35 AM. Diagnoses included, Alzheimer's disease with late onset.<br><br>A review of the physician orders indicated there were no active orders for the Nystatin Sus 100.<br><br>3. A record review of Resident 25, on 9/18/24 at 9:45 AM. Diagnoses included, Chronic Obstructive pulmonary disease.<br><br>A review of the physician ordersindicated to give Lidocaine 2% mucosal solution (generic) 15 milliliter (ml). Swish and spit every 8 hours before meals. | | medications identified will be removed and destroyed.<br>Licensed nursing and Qualified Medicaid Aides will receive inservice training on Facility's policy and procedure titled, "Medication Storage Policy." This inservice will be provided by DoN/designee.<br>An audit will be completed by licensed nursing staff three times a week for four weeks to assure that medication storage is in compliance with federal regulations. Then, an audit will be completed weekly for three months. Results of the audits, along with any other documentation, reports and/or observations that may indicate compliance status will be reviewed by the Quality Assurance committee during quarterly meetings for a period of one year to ensure substantial compliance is maintained. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155755 | A. BUILDING 00<br>B. WING | 09/23/2024 |

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

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| | A review of the MAR, dated September 2024, indicated Lidocaine 2% solution was given on the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17. There was no open date for this medication.<br><br>4. A record review of Resident 37, at 9/18/24 at 10:05 AM. Diagnoses included, Type 2 diabetes mellitus.<br><br>A review of the physician orders indicated to give Humalog U-100 insulin 100 units/ml-subcutaneous solution (insulin lispro)- 2 units subcutaneous three times a day for diabetes with each meal, and Insulin lispro ( U-100) 100 unit/ml subcutaneous solution (generic)-100 unit/ml: give<br>2 units- 201 through 250<br>4 units- 251 through 350<br>6 units- 351 through 400<br><br>A review of the MAR, dated September 2024, indicated Insulin lispro was given on the following dates: 17. The medication had expiration date of 9/16/24.<br><br>5. A record review of Resident 13 at 9/18/24 at 10:25 AM. Diagnoses included, Type 2 diabetes mellitus.<br><br>A review of the physician orders indicated to give Lantus INJ 100/ml-inject 50 units subcutaneous daily.<br><br>A review of the MAR, dated September 2024, indicated Lanuts INJ 100 units was given on the following dates: 15, 16, and 17. This medication had a expiration date of 9/14/24.<br><br>A current facility policy, Medication storage Policy, dated 10/27/22, was provided by the | | | |

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| | Director of Nursing on 9/18/24 at 8:51 AM. The policy indicated..." it is the policy of this facility to ensure all medications housed on out premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security...."<br><br>3.1-25(j)(m) and (n) | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br><br>Based on observation, interview and record review the facility failed to ensure infection control measures were maintained for oxygen tank tubing for 2 of 3 residents reviewed. (Resident 16 and Resident 247)<br><br>During an observation, on 9/17/24 at 12:20 PM, there were 2 oxygen tanks in the hallway on the floor. The tubing for both tanks were observed to be wrapped around the hand rail outside of the beauty shop. There were no covers, any bags, or dates observable for the tubing to be placed into.<br><br>In an interview, on 9/17/24 at 12:25 PM, the Director of Nursing (DON), indicated the resident would wear their oxygen to the beauty shop and leave the tank outside.<br><br>1. A record review of Resident 16 was completed on 9/17/24 at 1:05 PM. Diagnosis included, chronic obstructive pulmonary disease.<br><br>A physician order for Oxygen 2 liter (L)/ min, indicated to give nasal oxygen every shift for chronic obstructive pulmonary disease with (acute) exacerbation. | F 0880 | The oxygen tubing of Residents 16 and 247 has been replaced, dated and bagged/covered as needed.<br>The oxygen tubing of all residents will be dated and bagged/covered as needed.<br>Nursing staff and contracted beauticians will receive inservice training on Facility's policy and procedure related to oxygen administration and storage. This inservice will be provided by DoN/designee.<br>An audit will be completed by licensed nursing staff three times a week for four weeks to assure compliance with oxygen equipment storage requirements. Then, an audit will be completed weekly for three months. Results of the audits, along with any other documentation, reports and/or observations that may indicate compliance status will be reviewed by the Quality Assurance committee during quarterly | 10/17/2024 |

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| | 2. A record review of Resident 247 was completed on 9/17/24 at 1:05 PM . Diagnosis included, dependence on supplemental oxygen.<br><br>A physician order of Oxygen- 2L/min indicated to give nasal oxygen every shift for chronic obstructive pulmonary disease.<br><br>In an interview, on 9/19/24 at 9:00 AM, DON indicated the facility did not have a current facility policy.<br><br>3.1-18(a) | | meetings for a period of one year to ensure substantial compliance is maintained. | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaints IN00440829, IN00442467, and Complaint IN00443361.<br><br>Survey dates: September 17, 18, 19, 20, and 23, 2024.<br><br>Facility number: 000282<br><br>Residential Census: 42<br><br>Golden Years Homestead was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.<br><br>Quality review completed September 25, 2024 | 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 for the basis for the deficiencies. | |