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

FORM APPROVED
OMB NO. 0938-0391

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on December 9, 2016. This visit was in conjunction with the Investigation of Complaints IN00218235, IN00219453, and IN00220113. Complaint IN00218235 - Unsubstantiated due to lack of evidence. Complaint IN00219453 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441. Complaint IN00220113 - Substantiated. Federal/State deficiencies related to the allegations are cited at F246, F315, F441. Survey dates: January 25, 26, and 27, 2017. Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census bed type: SNF: 152 Total: 152	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Jason Eastlund, BSW, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census payor type: Medicare: 23 Medicaid: 115 Other: 14 Total: 152 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 1/31/17.			
F 0241 SS=D Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 0241	Res Identified Residents D and E both had their urine drainage bags placed in dignity	02/24/2017

Surveyor: Berber, Tammy

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

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	was observed in her room in bed. At that time, the urinary catheter drainage bag was laying on the floor uncovered. The record for Resident E was reviewed on 1/26/17 at 10:40 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, pseudobulbar affect, insomnia, hemiplegia, and anxiety disorder. The current and updated plan of care, dated 12/30/16, indicated the resident had an indwelling urinary catheter. The interventions included, but were not limited to, catheter care per staff. Interview with LPN #1 on 1/25/17 at 3:05 a.m., indicated the urinary catheter drainage bags should not have been on the floor and uncovered. Interview with Unit B Manager on 1/26/17 at 1:26 p.m., indicated the urinary catheter drainage bags should not be on the floor and uncovered. This deficiency was cited on 12/9/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-3(t)		basis.	

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F 0441 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;			

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	(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control policies and procedures	F 0441	Res Identified The employees who went into Resident B's isolated room were educated immediately. The soiled	02/24/2017

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	were maintained related to following isolation precautions and a soiled incontinence brief on the floor for 2 of 2 residents observed. (Residents B and C) Findings include: 1. On 1/26/17 at 9:24 a.m., the Physical Therapist (PT) was observed exiting Resident B's room with gloved hands, in her gloved right hand was a wadded piece of white linen. She walked down the hallway past the nursing station to the soiled utility room, where she entered the security code on the door panel and entered the room. She was then observed walking back down the hallway and re-entering the resident's room. She was not observed wearing a gown when she left the room, nor was she observed putting on a gown when she re-entered the room. Her hands remained gloved during the entire observation. Interview at the time with the Unit Manager, indicated the resident was on contact isolation for Clostridium Difficile (C. diff) a gastro-intestinal infection. The record for Resident B was reviewed on 1/26/17 at 1:39 p.m. Diagnoses included, but were not limited to, cerebral infarction, hemiplegia, diabetes, and hypertension. The 30-day Minimum Data Set (MDS) assessment, dated 1/13/17, indicated the		brief in resident C's room was disposed of properly. Others Facility managers did room rounds to identify any infection control issues. Education DCE/designee educated all staff related Infection control policy. Monitor DON/Designee will review all rooms for infection control issues 1 X per week for 4 weeks, 1 X per month for 3 months and then quarterly until 95% compliance is achieved. Facility leadership will observe care for patients in isolation 5 X per week for 4 weeks, 5 X per month for 3 months and then quarterly until 95% compliance is achieved. QAPI Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	

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	resident was severely impaired for decision making. The resident needed extensive assistance with a two person physical assist for bed mobility and transfers. A Physician's order dated 12/19/16 indicated contact isolation for C. diff. Interview with the PT on 1/26/17 at 1:06 p.m., indicated she was in the room completing an assessment on the resident's bilateral legs and noticed her flat sheet was disheveled. She then straightened the sheet and noticed that it was soiled with feces. She removed the sheet and disposed of it in the soiled utility room. She did not don a gown before entering the room, she did not double bag the soiled sheet before leaving the room, she did not remove her gloves and wash her hands before leaving the room, nor did she don a gown before re-entering the room. Interview with the Clinical Educator on 1/26/17 at 9:55 a.m., indicated the PT did not follow the facilities contact isolation precautions. 3. On 1/25/17 at 2:10 a.m., during the initial tour on Unit B, a dirty brief was observed on the floor near the garbage can in Resident C's room. Diagnoses included, but were not limited			

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	to, Parkinson's disease, mood disorder, abnormal gait and mobility, and psychotic disorder with delusions. Interview with LPN #1 on 1/25/17 at 2:33 a.m., indicated that the dirty brief did not belong on the floor and should have been thrown away. Interview with Unit B Manager on 1/26/17 at 1:26 p.m., indicated dirty briefs should not be on the floor and should have been thrown in the garbage. This deficiency was cited on 12/9/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(a)			
F 0465 SS=E Bldg. 00	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.			
	Based on observation and interview, the	F 0465	Res Identified	02/24/2017

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	facility failed to maintain a functional and sanitary environment related to marred walls, marred doors, chipped paint on door frames, peeling wall paper, dust on ceiling vents, dead insects inside window sills, buckled ceiling tiles, and dirty PVC piping on 3 of 4 units throughout the facility and in 1 of 1 kitchen areas. (Units B, D, E and Main Kitchen) Findings include: 1. During the Environmental tour with the Maintenance Supervisor and Administrator on 1/25/17 at 9:15 a.m., the following was observed: E wing: a. The door to Room 324 and the closet doors were scratched and marred. There were large areas of white spackle above bed 2 and the wall was marred by bed 1. Two residents resided in this room. b. The wall by the bathroom door in Room 326 was gouged and marred. There was cracked floor tile in the bathroom. One resident resided in this room. c. The wall behind the head of bed 1 in Room 327 was marred. The chair in the room was scratched and marred. The		All mentioned areas were addressed by maintenance and housekeeping prior to date of compliance. Others ED did a facility wide review of facility to identify any areas not mentioned in F tag 465. Education ED, Maintenance and housekeeping managers were educated on F tag 465 Monitor ED/Designee will do a weekly walk thru for 6 month, or until substantial compliance is achieved to ensure the affected areas are maintained. QAPI Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	

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	bathroom door frame had chipped paint. There was a section of peeling paint next to the toilet. Two residents resided in this room. d. The door frame to the "Diner" had chipped paint. The walls were marred throughout. There were sections of peeling wallpaper, and the furniture was marred and scratched. D wing: a. . The dresser, chair and closet doors were scratched and marred in room 337. Two residents resided in this room. b. In the Unit Dining Room, the walls and heat register were scratched and marred. The edges of the tables, in the dining room, were scratched and marred. c. The walls in the Living Room were scratched and marred. B wing: a. The walls in the bathroom of Room 106 were scratched and marred. The arms and legs of the chair were scratched and marred. One resident resided in this room. b. The arms and legs of the chair located			

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	next to bed 1 in Room 108 were scratched and marred. Two residents resided in this room. c. The wall behind the recliner in Room 123 was gouged and marred. The corner of the wall behind the toilet was discolored. Two residents resided in this room. d. The floor mats located next to both beds were stained in Room 128. Two residents resided in this room. 2. The following was observed during the Brief Kitchen Sanitation Tour on 12/5/16 at 8:55 a.m., with the Dietary Manager: Main Kitchen: a. There were food crumbs under the dish machine. b. There were dead insects noted on the window sill in the dish room. c. The floor tile was dirty in the dish room, the grout was also noted to be dirty and colored black. d. The outside of the garbage can by the hand washing sink was dirty under the lid, and noted to be black in color.			

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	e. The ceiling vent in the ice room was dirty with black dust. f. The ceiling in the ice room was dirty and the paint was buckling. g. There was adhered dirt noted on the floor tile, and the white PVC pipe under the food prep table was dirty. Interview with the Administrator at that time, indicated the kitchen / environment was not done and all of the above was in need of cleaning and or repair. This deficiency was cited on 12/9/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(f)			
F 9999 Bldg. 00		F 9999	NA	02/13/2017