

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/19/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374			
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F0000	<p>This visit was for the investigation of complaint number IN00116803.</p> <p>Complaint IN00116803 Substantiated, Federal/State deficiency related to the allegation are cited at F 282 and F323.</p> <p>Survey dates: October 18, 19, 2012</p> <p>Facility number: 000077 Provider number: 155157 AIM number: 100266490</p> <p>Survey team: Angel Tomlinson RN</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census payor type: Medicare: 16 Medicaid: 72 Other: 8 Total: 96</p> <p>Sample: 3</p> <p>These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2.</p>	F0000					

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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	Quality review completed 10/22/12 Cathy Emswiller RN			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to implement a physicians order for one to one supervision during meals for 1 of 3 residents sampled for physician orders in a total sample of 3 (Resident #B).</p> <p>Finding include:</p> <p>During initial tour of the facility on 10-18-12 at 9:30 a.m. Unit Manager #1 indicated Resident #B had a recent hospitalization for pneumonia and required a puree (food blended until smooth) and thickened liquid diet.</p> <p>During observation on 10-18-12 at 12:05 p.m. Resident #B was eating lunch in her room with no staff present, the resident had puree chicken enchilada, puree black bean salad, puree sugar cookie and honey thickened shake. Resident #B indicated she liked to eat her lunch in the dining room and the reason she was not eating her lunch in the dining room was because she did not know where her wheelchair was.</p>	F0282	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R#B's care plan was reviewed and updated as indicated on 10-18-12. R#B's CNA assignment sheet was reviewed and updated as indicated on 10-18-12. On 10-19-12 all CNA's who care for R#B were in-serviced on offering 1:1 supervision during meals when resident eats in her room. Tracking when resident eats in her room will be documented on the MAR. On 10-18-12 The charts of all resident with the potential to choke were audited to review diet orders and instructions regarding eating with supervision. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Residents with an order for 1:1 supervision were reviewed and new interventions implemented if indicated. C.N.A. assignment sheets were reviewed to</p>	11/02/2012	

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	<p>Interview with LPN #2 on 10-18-12 at 12:35 p.m. indicated the nurses knew which residents require one to one supervision during meals and the CNA's knew which residents required supervision during meals because it was on the CNA assignment sheet.</p> <p>Review of the CNA assignment sheet on 10-18-12 at 1:00 p.m. indicated Resident #B's breakfast was served in her room and lunch/dinner were in the dining room. The resident had a puree honey thick liquid diet. The CNA assignment sheet did not indicate the resident required one to one supervision during meals.</p> <p>Review of the record of Resident #B on 10-18-12 at 3:30 p.m. indicated the resident's diagnoses included, but were not limited to, Chronic Airway Obstruction, pneumonia, dysphasia (difficulty swallowing), anxiety and acute respiratory failure.</p> <p>The physician diet order for Resident #B, dated 9-13-12 indicated the resident was to have a puree fluid consistency diet with honey thickened liquids. Patient has a signed waiver on file for a regular diet.</p> <p>The Minimum Data Set (MDS) assessment for Resident #B, dated 9-19-12 indicated the resident's BIMS</p>		<p>ensure residents who require 1:1 supervision were updated as indicated. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: On 10-19-12 all CNA's who care for R#B were in-serviced on offering 1:1 supervision during meals. Two nurses will check and verify physician orders upon admission/readmission to the facility and a third nurse to review and verify accuracy of orders within 24 hours of admission. DNS/Designee will audit new admission charts for physician diet orders and will update as needed resident care plans for 1:1 supervision during meals, MAR's and C.N.A. assignment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 3 months or longer if needed until compliant . These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will audit new admission charts for physician orders for 1:1 supervision during meals, resident care plans for 1:1 supervision during meals and C.N.A.</p>				

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	<p>(Brief Interview for Mental Status) was 15, with a range of 13-15, indicating the resident was cognitively intact, eating was limited assistance of one person, coughing or choking during meals or when swallowing medications and had a mechanically altered diet.</p> <p>The progress note for Resident #B, dated 9-9-12 at 8:45 p.m. indicated the resident nurse was called to the resident's room because the resident states she can not breathe well. The resident was clinging to the siderails repeating "help me please" The resident's oxygen saturation was 34%, respirations were labored and shallow. The resident was grunting with expiration. The resident was given a breathing treatment and her oxygen saturation increased to 78%. The resident was on 4 liters of oxygen by a nasal canula. The physician was notified and an order was received to send the resident to the Emergency Room. The progress note was signed by RN #3.</p> <p>The local hospital history and physical for Resident #B, dated 9-10-12 indicated the resident had recurrent aspiration pneumonia. The resident had shortness of breath, coughing and did not feel well. The resident was sent to the ER for further evaluation. The resident had infiltrates consistent with pneumonia. It</p>		<p>assignment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 3 months or longer if needed until compliant with no issues identified. Results of audits will be reviewed at the monthly QAA meetings for 6 months or longer if needed until compliant with no issues identified. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>was felt she had aspiration pneumonia and was admitted. The resident will be treated with Intravenous (IV) antibiotics and will continue on pureed and pudding thick liquid diet.</p> <p>The local hospital discharge order for Resident #B, dated 9-13-12 indicated the resident was ordered a puree diet with honey thickened liquids, 1:1 supervision and comfort foods PRN (as needed).</p> <p>Interview with Unit Manager #1 on 10-18-12 at 4:00 p.m. indicated she was unaware of the discharge order from the local hospital for Resident #B to have one on one supervision during meals. Unit Manager #1 indicated RN# 4 had taken care of the orders when Resident #B arrived back from the hospital on 9-13-12.</p> <p>Interview with Resident #B on 10-19-12 at 8:30 a.m. indicated she did remember going to the hospital in September 2012, but did not remember why she had went to the hospital. Resident #B indicated she was not aware the hospital physician wanted someone to stay with her during meals.</p> <p>Interview with the Director Of Nursing (DON) on 10-19-12 at 9:05 a.m. indicated she had talked with RN #4. The DON indicated that RN #4 did not remember</p>				

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	<p>the discharge orders specifying for Resident #B to be one to one during meals.</p> <p>This federal tag relates to Complaint number IN00116803.</p> <p>3.1-35(g)((2)</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to provide one to one supervision during meals to prevent potential aspiration for 1 of 3 residents sampled for accidents in a total sample of 3 (Resident #B).</p> <p>Finding include:</p> <p>During initial tour of the facility on 10-18-12 at 9:30 a.m. Unit Manager #1 indicated Resident #B had a recent hospitalization for pneumonia and required a puree (food blended until smooth) and thickened liquid diet.</p> <p>During observation on 10-18-12 at 12:05 p.m. Resident #B was eating lunch in her room with no staff present, the resident had puree chicken enchilada, puree black bean salad, puree sugar cookie and honey thickened shake. Resident #B indicated she liked to eat her lunch in the dining room and the reason she was not eating her lunch in the dining room was because she did not know where her wheelchair was.</p>	F0323	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R#B's care plan was reviewed and updated as indicated on 10-18-12. R#B's CNA assignment sheet was reviewed and updated as indicated on 10-18-12. On 10-19-12 all CNA's who care for R#B were in-serviced on offering 1:1 supervision during meals when resident eats in her room. Tracking when resident eats in her room will be documented on the MAR. On 10-18-12 the charts of all resident with the potential to choke were audited to review diet orders and instructions regarding eating with supervision. On 10-19-12 all CNA's who care for R#B were in-serviced on offering 1:1 supervision during meals when resident eats in her room. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p>	11/02/2012	

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	<p>Interview with LPN #2 on 10-18-12 at 12:35 p.m. indicated the nurses knew which residents require one to one supervision during meals and the CNA's knew which residents required supervision during meals because it was on the CNA assignment sheet.</p> <p>Review of the CNA assignment sheet on 10-18-12 at 1:00 p.m. indicated Resident #B's breakfast was served in her room and lunch/dinner were in the dining room. The resident had a puree honey thick liquid diet. The CNA assignment sheet did not indicate the resident required one to one supervision during meals.</p> <p>Review of the record of Resident #B on 10-18-12 at 3:30 p.m. indicated the resident's diagnoses included, but were not limited to, Chronic Airway Obstruction, pneumonia, dysphagia (difficulty swallowing), anxiety and acute respiratory failure.</p> <p>The physician diet order for Resident #B, dated 9-13-12 indicated the resident was to have a puree fluid consistency diet with honey thickened liquids. Patient has a signed waiver on file for a regular diet.</p> <p>The Minimum Data Set (MDS) assessment for Resident #B, dated</p>		<p>Residents with an order for 1:1 supervision were reviewed and new interventions implemented if indicated. C.N.A. assignment sheets were reviewed to ensure residents who require 1:1 supervision were updated as indicated. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: On 10-19-12 all CNA's who care for R#B were in-serviced on offering 1:1 supervision during meals. Two nurses will check and verify physician orders upon admission/readmission to the facility and a third nurse to review and verify accuracy of orders within 24 hours of admission. DNS/Designee will audit new admission charts for physician diet orders and will update as needed resident care plans for 1:1 supervision during meals and C.N.A. assignment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks then monthly for 3 months or longer if needed until compliant with no issues identified. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p>		

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	<p>9-19-12 indicated the resident's BIMS (Brief Interview for Mental Status) was 15, with a range of 13-15, indicating the resident was cognitively intact, eating was limited assistance of one person, coughing or choking during meals or when swallowing medications and had a mechanically altered diet.</p> <p>The "INFORMED CONSENT and RELEASE of LIABILITY" signed by Resident #B on 12-14-11 indicated the Speech Language Pathologist had determined the resident was at high risk for food entering and obstructing the resident's airway. "If food enters and obstructs the airway, it could result in pneumonia, pnuemonitis and/or death." "Total obstruction of your airway could cause serious brain injury and/or death by suffocation." "Additionally, your compromised ability to swallow increases the likelihood of poor nutrition from the decreased consumption of food." "For these reasons it has been recommended that you receive a pureed diet with pudding thick liquids." "You are making an informed choice to refuse the recommendations and continue with regular fluids and food."</p> <p>The progress note for Resident #B, dated 9-9-12 at 8:45 p.m. indicated the resident nurse was called to the resident's room</p>		<p>DNS/Designee will audit new admission charts for physician orders for 1:1 supervision during meals, resident care plans for 1:1 supervision during meals, MAR's and C.N.A. assignment sheets 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 3 months or longer if needed until compliant with no issues identified. Results of audits will be reviewed at the monthly QAA meetings for 6 months or longer if needed until compliant with no issues identified. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>				

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	<p>because the resident states she can not breathe well. The resident was clinging to the siderails repeating "help me please" The resident's oxygen saturation was 34%, respirations were labored and shallow. The resident was grunting with expiration. The resident was given a breathing treatment and her oxygen saturation increased to 78%. The resident was on 4 liters of oxygen by a nasal canula. The physician was notified and an order was received to send the resident to the Emergency Room. The progress note was signed by RN #3.</p> <p>The local hospital history and physical for Resident #B, dated 9-10-12 indicated the resident had recurrent aspiration pneumonia. The resident had shortness of breath, coughing and did not feel well. The resident was sent to the ER for further evaluation. The resident had infiltrates consistent with pneumonia. It was felt she had aspiration pneumonia and was admitted. The resident will be treated with Intravenous (IV) antibiotics and will continue on pureed and pudding thick liquid diet.</p> <p>The local hospital physician documentation for Resident #B, dated 9-10-12 at 8:45 p.m. indicated the resident was sent from the facility for an evaluation of respiratory distress. The</p>				

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	<p>paramedics who brought her in reported to the physician that the resident became rather suddenly dyspneic shortly after eating. The facility staff told the paramedics they thought the resident had aspirated and that seemed clinically likely. The resident says "I just can't breathe." The admitting diagnosis was aspiration pneumonia with respiratory distress and hypoxia.</p> <p>The local hospital discharge order for Resident #B, dated 9-13-12 indicated the resident was ordered a puree diet with honey thickened liquids, 1:1 supervision and comfort foods PRN (as needed). The resident refused a feeding tube and wants to be kept comfortable.</p> <p>Interview with Unit Manager #1 on 10-18-12 at 4:00 p.m. indicated she was unaware of the discharge order from the local hospital for Resident #B to have one on one supervision during meals. Unit Manager #1 indicated RN# 4 had taken care of the orders when Resident #B arrived back from the hospital on 9-13-12.</p> <p>Interview with Resident #B on 10-19-12 at 8:30 a.m. indicated she did remember going to the hospital in September 2012, but did not remember why she had went to the hospital. Resident #B indicated she was not aware the hospital physician</p>				

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	<p>wanted someone to stay with her during meals. Resident #B indicated it would be ok if one staff stayed with her while she ate her meals.</p> <p>Interview with the Director Of Nursing (DON) on 10-19-12 at 9:05 a.m. indicated she had talked with RN #4. The DON indicated that RN #4 did not remember the discharge orders specifying for Resident #B to be one to one during meals. The DON indicated she felt that Resident #B did not choke on 9-9-12 and had become short of breath. The DON indicated the resident was served supper around 5:00 p.m. that evening and the incident happened at 8:45 p.m. The DON indicated if the facility had any incidents of choking there would have been an incident report filled out and there was none for Resident #B regarding the hospitalization on 9-9-12.</p> <p>Interview with RN #3 on 10-19-12 at 10:10 a.m. indicated she was the nurse on 9-9-12 when Resident #B was sent to the hospital. RN #3 indicated CNA's came to her while she was passing medication and told her Resident #B having trouble breathing. RN #3 indicated when she entered the resident's room the resident had labored breathing and was gripping the siderails on her bed. RN #3 indicated she gave the resident a breathing</p>						

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	<p>treatment and the resident's oxygen level improved. RN #3 indicated she did not know if Resident #B had a snack that evening. RN #3 indicated the incident happened really fast. RN #3 indicated when she gave report to the hospital she did tell the hospital the resident may have aspirated because of the resident's history.</p> <p>This federal tag relates to Complaint number IN00116803.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>				