

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F000000	<p>This visit was for the Investigation of Complaint IN00154838.</p> <p>Complaint IN00154838- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309, F315, F329, F441, F465, F507.</p> <p>Survey dates: August 26 and 27, 2014</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Survey team: Regina Sanders, RN-TC</p> <p>Census bed type: SNF/NF: 132 Total: 132</p> <p>Census Payor type: Medicare: 09 Medicaid: 109 Other: 14 Total: 132</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000		
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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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F000157 SS=D	<p>Quality review completed on August 29, 2014, by Janelyn Kulik, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in</p>			

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	<p>§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure a resident's physician was notified, related to a complaint of hurting after urinating and when the facility was unable to obtain a urine specimen as ordered, for 1 of 4 residents reviewed for a urinary tract infection, in total sample of 7. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 08/26/14 at 11:14 a.m. The resident's diagnoses included, but were not limited to, hypertrophy of the prostate, chronic kidney disease, and congestive heart failure.</p> <p>A Significant Change Minimum Data Set assessment, dated 07/17/14, indicated the resident's cognition was moderately impaired, required extensive assistance of two for toileting, and was always incontinent of bowel and bladder.</p> <p>A) During an interview with Resident</p>	F000157	<p>F157</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>We are unable to correct the alleged deficient practice for Resident B</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Residents who have complaints of pain upon urination have the potential to be affected by the deficient practice. Staff were interviewed to determine if any residents are having complaints of hurting after urination and if the physician was notified. The facility did not identify any other residents that did not have physician notification.</p>	09/26/2014

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	<p>#B's family member, on 08/26/14 at 1:31 p.m., she indicated she had reported to LPN #1 on 07/17/14, her father was having stomach pain and increased pain with urinating. A memo was reviewed on the family members phone, with the date and the nurse she had spoken with. She indicated LPN #1 had said she would call the resident's physician. The family member indicated on 08/07/14 Resident #B voiced to her again he had stomach pain and increased pain after urinating. The family member indicated she reported this again to a nurse and then found out the resident's physician had not been notified the when first reported on 07/17/14.</p> <p>During an interview on 08/26/14 at 2:52 p.m., LPN #1 indicated she recalled the resident's family member saying something to her, "awhile ago", but could not recall the date. She indicated the family member had informed her the resident had said he had pain. She indicated she had reported the concern to the Unit Manager. She indicated when she asked the resident he had told her he was not having pain. She indicated she did not remember what happened that day and indicated she was still fairly new to the facility then. She indicated she had not notified the physician. She further indicated she assessed the resident and he</p>		<p>Residents who have u/a c&s ordered have the potential to be affected. Reviewed residents with orders for u/a c&s over the past 14 days to determine if the specimen was able to be obtained and if not the MD notified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Nurses were re-educated on the Guideline: Notification of Change in Resident Health Status. Nurse competency was evaluated with a post education Quiz.</p> <p>Nurse managers will review progress notes to ensure physician is notified of resident/families complaints of clinical change of condition.</p> <p>Nurses will complete the Diagnostic Tracking form each time an order is received for a u/a c&s and notify the physician if unable to obtain the specimen within 24 hrs.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p>	

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	<p>told her it did not hurt when he urinated. She further indicated she remembered the resident's daughter had informed her the resident was having pain after he urinated.</p> <p>During an interview on 08/26/14 at 3:38 p.m., the D-Wing Unit Manager indicated she did not recall being informed of the concern in July until in August when the family member voiced a concern about the physician not being notified and the resident was not checked for a urinary tract infection. She indicated she had spoke to LPN #1 and LPN #1 informed her she had totally forgot because there was so much going on that night. The D-Wing Unit Manager indicated LPN #1 should have completed and documented an assessment and should have notified the resident's physician to ask for a laboratory tests.</p> <p>During an interview on 08/27/14 at 9:35 a.m., the Director of Nursing (DoN) and the Administrator indicated they were unaware of concerns from the family about Resident #B's stomach pain and pain after urinating concerns in July.</p> <p>Review of the resident's Nurses' Notes, dated 07/17/14, lacked documentation to indicate the resident was assessed for stomach pain and pain after urinating.</p>		<p>Unit managers will bring Diagnostic Tracking form to Clinical start up 5x weekly for review by the DNS to ensure the deficient practice does not recur.</p> <p>Results will be brought to QAPI monthly for a minimum of 6 months by the DNS or designee</p> <p>By what date the systemic changes will be completed? 9/26/2014</p>		

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	<p>There was a lack of documentation to indicate the resident's physician had been notified of the pain.</p> <p>B) Resident #B's progress notes indicated:</p> <p>08/07/14 at 11:05 p.m., "Resident c/o (complains of) pain after urination. Resident denied burning during urination, but stated 'it hurts for about 5 minutes after I go'...Called out to (Physician's Name). New order to obtain UA (urinalysis) and C and S (culture and sensitivity)..."</p> <p>08/08/14 at 5:55 a.m.- "...attempted to collect U/A et unsuccessful..."</p> <p>08/08/14 at 1:51 p.m.- "...no c/o pain during or after urination within shift. Urine not obtained within shift..."</p> <p>08/08/14 at 10:46 p.m.- "Attempted to obtain UA. Was unsuccessful..." (24 hours after order received)</p> <p>08/09/14 at 10:27 p.m. (resident was out on pass with family until 9:47 p.m.) -"Unable to obtain urine sample for resident..." (48 hours after order received)</p> <p>08/10/14 at 5:53 a.m.- "Writer and another nurse attempted this am</p>			

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	<p>(morning) to obtain U/A via straight cath (catheter). Attempt unsuccessful. Resident voided a large amount of yellow urine this shift..."</p> <p>(No documented attempts to obtain the urine specimen on the day shift)</p> <p>08/10/14 at 10:28 p.m.- "Unable to obtain urine sample for resident..." (72 hours after order received)</p> <p>08/11/14 at 5:57 a.m.- "Writer attempted this shift to straight cath resident for urine sample. Unable to obtain. Resident voiding adequately-brief was noted to have moderate amt (amount) yellow urine...Will inform day shift that several attempts have been made to collect urine sample via straight cath, and all have been unsuccessful."</p> <p>08/11/14 at 2:54 p.m.-Change of Condition note indicated the resident's oxygen saturation was 84% (normal 90-100%), oxygen was started, the resident was more confused and the resident's physician was notified with orders to transfer the resident to the Emergency Room.</p> <p>There was a lack of documentation to indicate the resident's physician had been notified prior to the decrease of the</p>			

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	<p>oxygen saturation, the facility was unable to obtain a urine sample as ordered for the UA and urine culture and sensitivity.</p> <p>During an interview on 08/27/14 at 8:58 a.m., the D-Wing Unit Manager indicated she was not informed the nurses' could not obtain the urine sample until 08/11/14. She indicated every shift should have attempted to get the urine sample. She indicated the physician should have been notified when they were unable to obtain the urine sample.</p> <p>An undated facility policy, received from the Assistant Director of Nursing as current on 08/26/14 at 2:14 p.m., titled, "...(B) Acute illness or a significant change in the resident's physical, mental, or psychosocial status...recurrent urinary tract infection...Appropriate notification time: immediate..."</p> <p>This Federal Tag relates to complaint IN00154838.</p> <p>3.1-5(a)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide necessary care and services, related to a resident was not assessed for stomach pain and pain after urination after the nurse was informed of the complaint, for 1 of 4 residents reviewed for urinary tract infections in a total sample of 7. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 08/26/14 at 11:14 a.m. The resident's diagnoses included, but were not limited to, hypertrophy of the prostate, chronic kidney disease, and congestive heart failure.</p> <p>A Significant Change Minimum Data Set assessment, dated 07/17/14, indicated the resident's cognition was moderately impaired, required extensive assistance of two for toileting, and was always incontinent of bowel and bladder.</p>	F000309	F309 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. We are unable to correct the alleged deficient practice for Resident B How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents who have complaints of pain upon urination have the potential to be affected by the deficient practice. Staff were interviewed to determine if any residents are having complaints of hurting after urination and if an assessment was completed and documented. The facility did	09/26/2014			

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	<p>During an interview with Resident #B's family member, on 08/26/14 at 1:31 p.m., she indicated she had reported to LPN #1 on 07/17/14, her father was having stomach pain and increased pain with urinating. A memo was reviewed on the family members phone, with the date and the nurse she had spoken with. She indicated LPN #1 had said she would call the resident's physician. The family member indicated on 08/07/14 Resident #B voiced to her again he had stomach pain and increased pain after urinating. The family member indicated she reported this again to a nurse and then found out the resident's physician had not been notified the when first reported on 07/17/14.</p> <p>During an interview on 08/26/14 at 2:52 p.m., LPN #1 indicated she recalled the resident's family member saying something to her, "awhile ago", but could not recall the date. She indicated the family member had informed her the resident had said he had pain. She indicated she had reported the concern to the Unit Manager. She indicated when she asked the resident he had told her he was not having pain. She indicated she did not remember what happened that day and indicated she was still fairly new to the facility then. She then indicated she assessed the resident and he told her</p>		<p>not identify any other residents that did not have an assessment.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Nurses were re-educated on the Clinical Health Status/Change of Condition Guideline. Nurse competency was evaluated with a post education Quiz.</p> <p>Nurse managers will review progress notes to ensure an assessment is documented for any resident who has a complaint or clinical change of condition.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Change of Condition audit will be completed 5x weekly and reviewed during Clinical Start up. Results will be reviewed by DNS and brought to QAPI monthly for a minimum of 6 months.</p>				

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F000315 SS=D	<p>it did not hurt when he urinated. She then indicated she remembered the resident's daughter had informed her the resident was having pain after he urinated.</p> <p>During an interview on 08/26/14 at 3:38 p.m., the D-Wing Unit Manager indicated LPN #1 should have completed and documented an assessment and should have notified the resident's physician to ask for a laboratory tests.</p> <p>During an interview on 08/27/14 at 9:35 a.m., the Director of Nursing (DoN) and the Administrator indicated they were unaware of concerns from the family about Resident #B's stomach pain and pain after urinating concerns in July.</p> <p>Review of the resident's Nurses' Notes, dated 07/17/14, lacked documentation to indicate the resident was assessed for stomach pain and pain after urinating.</p> <p>This Federal Tag relates to complaint IN00154838.</p> <p>3.1-37(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE</p>		By what date the systemic changes will be completed? 9/26/14	

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	<p>BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to treat a resident with an urinary tract infection (UTI) with the appropriate medication, related to not obtaining the urine culture and sensitivity (C&S) timely. The resident continued to have pain and difficulty urinating during the inappropriate treatment, for 1 of 3 residents being treated for a UTI. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's record was reviewed on 08/26/14 at 10:39 a.m. The resident's diagnoses included, but were not related to, incomplete bladder emptying and convulsions.</p> <p>A Physician's Order, dated 08/16/14, indicated an order for a urinalysis (UA) and C&S (culture and sensitivity).</p> <p>A Progress note, dated 08/17/14 at 9:03</p>	F000315	<p>F315</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The MD of resident D was notified on 8/26/14 and a new order for antibiotic therapy was obtained.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Other residents with u/a c&s ordered have the potential to be affected. Facility reviewed residents with orders over the past 14 days to ensure final c&s was obtained and resident was receiving an appropriate antibiotic.</p>	09/26/2014			

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	<p>p.m., indicated the urine specimen had been obtained.</p> <p>The Urinalysis results, dated 08/18/14 and received on 08/19/14, indicated the urine had high amount of white blood cells, 50 red blood cells, and moderate amount of bacteria.</p> <p>A Physician's order, dated 08/21/14 indicated an order for Cipro (antibiotic) 500 mg (milligrams) twice daily for UTI for seven days.</p> <p>The Medication administration record, dated 08/14, indicated the resident received the Cipro 500 mg twice daily 08/21/14 through 08/26/14.</p> <p>The Progress notes indicated: 08/20/14 at 4:46 a.m.- "...Resident complained of burning upon urination..."</p> <p>08/21/14 at 4:58 a.m.- "...Resident complained of mild burning upon urination, stating 'it burns a little'..."</p> <p>08/21/14 at 5:48 p.m.- "...Resident voices burning upon urination..."</p> <p>08/24/14 at 5:05 a.m.- "...Resident continues to c/o (complain of) dysuria (difficulty urinating)..."</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Nurses were re-educated on Lab Processing/Tracking Guideline and Diagnostic Tracking form. Nurse competency was evaluated with a post education Quiz.</p> <p>Nurses will complete the Diagnostic Tracking form each time they receive an order for a u/a c&s. This form will be reviewed by each shift and updated until the final c&s is received and the MD is notified.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Unit managers will bring Diagnostic Tracking form to Clinical start up 5x weekly for review by the DNS to ensure the deficient practice does not recur.</p> <p>Results will be brought to QAPI monthly for a minimum of 6 months by the DNS or designee</p>		

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	<p>There was a lack of documentation in the resident's record to indicate the urine C&S result had been received by the facility.</p> <p>During an interview on 08/26/14 at 11:03 a.m., LPN #2 indicated the facility had not received the results of the urine C&S. She indicated the laboratory company was faxing the results to the facility.</p> <p>Review of the urine C&S results, received 08/26/14 at 11:23 a.m., indicated the resident had >100,000 colonies per milliliter of Proteus mirabilis and the Ciprofloxacin (Cipro) was more than two resistant to the organism.</p> <p>During an interview on 08/26/14 at 11:18 a.m., the D-Wing Unit Manager acknowledged the resident had been receiving the wrong medication for the organism in the urine. She indicated an urine C&S result should be returned to the facility within 48 hours. She indicated it was everyone's responsibility to ensure the facility received the results.</p> <p>This Federal Tag relates to complaint IN00154838.</p> <p>3.1-41(a)(2)</p>		<p>By what date the systemic changes will be completed?</p> <p>9/26/2014</p>	

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from an unnecessary drug, related to the administration of an antibiotic which was resistant to the type of organism it was ordered to treat, for 1 of 3 residents being treated for an urinary tract infection (UTI) in a total sample of 7. (Resident #D)</p>	F000329	<p>F329</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The MD of resident D was notified on 8/26/14 and a new order for antibiotic therapy was obtained.</p>	09/26/2014

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	<p>Findings include:</p> <p>Resident #D's record was reviewed on 08/26/14 at 10:39 a.m. The resident's diagnoses included, but were not related to, incomplete bladder emptying and convulsions.</p> <p>A Physician's Order, dated 08/16/14, indicated an order for a urinalysis (UA) and C&S (culture and sensitivity).</p> <p>A Progress note, dated 08/17/14 at 9:03 p.m., indicated the urine specimen had been obtained.</p> <p>The Urinalysis results, dated 08/18/14 and received on 08/19/14, indicated the urine had high amount of white blood cells, 50 red blood cells, and moderate amount of bacteria.</p> <p>A Physician's order, dated 08/21/14 indicated an order for Cipro (antibiotic) 500 mg (milligrams) twice daily for UTI for seven days.</p> <p>The Medication administration record, dated 08/14, indicated the resident received the Cipro 500 mg twice daily 08/21/14 through 08/26/14.</p> <p>There was a lack of documentation in the resident's record to indicate the urine</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Other residents with u/a c&s ordered have the potential to be affected. Facility reviewed residents with orders over the past 14 days to ensure final c&s was obtained and resident was receiving an appropriate antibiotic.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Nurses were re-educated on Lab Processing/Tracking Guideline and Diagnostic Tracking form. Nurse competency was evaluated with a post education Quiz.</p> <p>Nurses will complete the Diagnostic Tracking form each time they receive an order for a u/a c&s. This form will be reviewed by each shift and updated until the final c&s is received and the MD is notified.</p>	

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F000441 SS=E	<p>C&S result had been received by the facility.</p> <p>During an interview on 08/26/14 at 11:03 a.m., LPN #2 indicated the facility had not received the results of the urine C&S. She indicated the laboratory company was faxing the results to the facility.</p> <p>Review of the urine C&S results, received 08/26/14 at 11:23 a.m., indicated the resident had >100,000 colonies per milliliter of Proteus mirabilis and the Ciprofloxacin (Cipro) was more than two resistant to the organism.</p> <p>During an interview on 08/26/14 at 11:18 a.m., the D-Wing Unit Manager acknowledged the resident had been receiving the wrong medication for the organism in the urine.</p> <p>This Federal Tag relates to complaint IN00154838.</p> <p>3.1-48(a)(4)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Unit managers will bring Diagnostic Tracking form to Clinical start up 5x weekly for review by the DNS to ensure the deficient practice does not recur.</p> <p>Results will be brought to QAPI monthly for a minimum of 6 months by the DNS or designee</p> <p>By what date the systemic changes will be completed? 9/26/14</p>		

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	<p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record observation, record review, and interview, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection,</p>	F000441	F441 What corrective action(s) will be accomplished for those residents found to have	09/26/2014

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	<p>related to storing unlabeled bath basins, bedpans, and urine collection canisters on the floor in the bathroom on 2 of 3 Wings, which had the potential to effect 16 resident. (C-Wing and D-Wing)</p> <p>Findings include:</p> <p>1. During the initial tour of the C-Wing, with the C-Wing Unit Manager present, on 08/26/14 from 9 a.m. to 9:10 a.m., the following was observed:</p> <p>There was an uncovered bedpan stored on the bathroom floor in room 207. There was one resident who resided in the room. The C-Wing Unit Manager indicated the bedpans should not be stored on the floor.</p> <p>There was a bath basin stored on the bathroom floor in room 222. There was one resident who resided in the room.</p> <p>There were three unlabeled bath basins, stacked together stored on the floor in the bathroom of room 226. There were two residents who resided in the room. The C-Wing Unit Manager indicated the bath basins would go into the trash.</p> <p>There was two unlabeled stacked together bath basins stored on the bathroom floor in room 229. There are two residents</p>		<p>been affected by the deficient practice.</p> <p>Residents found to be affected by the alleged deficient practice had basins/bedpans and or urine collection canisters removed from their room and placed in trash.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents in rooms with basins/bedpans and or urine collection canisters in their bathrooms have the potential to be affected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Nurses and CNA staff will be re-educated on storage of basins/bedpans and urine collection canisters.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p>	

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	<p>who reside in the room. The C-Wing Unit Manager indicated, "seems to be ongoing".</p> <p>2. During the initial tour of the D-Wing, with the D-Wing Unit Manager present, on 08/26/14 from 9:13 a.m. through 9:41 a.m., the following was observed:</p> <p>There was an unlabeled bath basin in plastic stored on the floor in the bathroom in room 306. There were two residents who resided in the room. The D-Wing Unit Manager indicated the basin was not labeled and she did not know which resident the basin belonged to.</p> <p>There was two unlabeled, stacked bath basins and an unlabeled urine collection container stored on the floor in room 309. There were two residents who resided in the room. CNA #3 indicated she was not sure which basins were used for which resident.</p> <p>There was two unlabeled, stacked bath basins stored on the floor in the bathroom in room 317. There were two residents who resided in the room.</p> <p>There was an unlabeled bedpan stored on the floor in the bathroom of room 322. There were two residents who resided in</p>		<p>Infection Control Audit will be completed by midnight nurses and reviewed by unit managers 5x week x 4 weeks, weekly x 8 weeks and then monthly x 3 months. Results of audits will be reviewed by DNS or designee and brought to QAPI monthly x 6 months.</p> <p>By what date the systemic changes will be completed? 9/26/2014</p>				

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	<p>the room.</p> <p>There was an unlabeled bath basin stored on the floor in the bathroom in room 330. There were two residents who resided in the room.</p> <p>An Infection Control Program Guidelines, titled, "Patient/Resident Care", and received from the Director of Nursing as current on 08/26/14 at 3:08 p.m., indicated, "It is the policy of this facility to appropriately handle patient/resident care use items and body/blood fluids as potentially hazardous per the Bloodborne Pathogen Standard definitions. Urine and feces...Utensils (bedpans...) are to be washed with antimicrobial soap and water and returned to the same patient/resident..."</p> <p>This Federal Tag relates to complaint IN00154838.</p> <p>3.1-18(b)(1)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, record review, and interview, the facility failed to provide a sanitary and clean environment for residents, related to dirty floor mats, floors, and bedside tables, soiled briefs on the bathroom floor, dried brown substance on a sheet, dried liquid substance on the floor, dirty wheelchair, and cracked and bubbled plaster on the walls, for 14 of 57 resident rooms, on 2 of 3 Wings (C-Wing and D-Wing), which had the potential to affect 23 residents.</p> <p>Findings include:</p> <p>1. During the initial tour of the C-Wing, with the C-Wing Unit Manager present, on 08/26/14 from 9 a.m. to 9:10 a.m., the following was observed:</p> <p>The over bed table was dirty, the room floor had debris, and the corners of the bathroom floor had an accumulation of dirt in room 207. There was one resident who resided in the room.</p> <p>The bed in 222 had just a bottom sheet on</p>	F000465	<p>F465</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Residents found to be affected by the deficient practice had their sheets changed and wheelchairs cleaned.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Residents on the 2 wings have the potential to be affected by the alleged deficient practice. Residents found with dirty sheets will have their sheets changed and residents with dirty wheelchairs will have their wheelchairs cleaned.</p> <p>What measures will be put into place or what systemic changes</p>	09/26/2014

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	<p>it and there was a dark brown dried liquid substance on the sheet. The C-Wing Unit Manager indicated the resident was in the hospital and the bed had not been stripped yet. She indicated the brown substance could be food. (The resident was transferred to the hospital on 08/25/14 at 1:02 p.m.-per the Progress Notes).</p> <p>There was a dried light brown substance on the floor next to the feeding tube pole and a beige colored substance on the side of the bed, which looked like a shoe print in room 227. There was two residents who resided in the room. The C-Wing Unit Manager indicated the dried substance on the floor could be from the feeding tube and acknowledged the beige colored substance looked like a shoe print.</p> <p>2. During the initial tour of the D-Wing, with the D-Wing Unit Manager present, on 08/26/14 from 9:13 a.m. through 9:41 a.m., the following was observed:</p> <p>There was dirt on the floor, accumulation of dirt under the closet doors, dirt on the floor pad, and the bathroom floor was dirty in room 303. There was one resident who resided in the room. The D-Wing Unit Manager acknowledged the observation.</p>		<p>will be made to ensure that the deficient practice does not recur.</p> <p>Re-educated nurses and CNA staff on the following items: Changing of sheets prn when dirty and removing from the bed when a resident is sent to the hospital. Cleanliness of wheelchairs. Re-educated nurses and CNA staff to alert social services if a resident has a behavior of throwing their brief on the floor.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Infection Control Audit will be completed by midnight nurses and reviewed by unit managers 5x week x 4 weeks, weekly x 8 weeks and then monthly x 3 months. Results of audits will be reviewed by DNS or designee and brought to QAPI monthly x 6 months.</p> <p>By what date the systemic changes will be completed? 9/26/2014 F465</p> <p>Regarding Maintenance: An immediate sweep was done of</p>				

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	<p>The mat on the floor by the window bed in room 306 was dirty. There were two residents who resided in the room.</p> <p>There was dried liquid rings on the bedside table and soiled briefs on the bathroom floor in room 309. There were two residents who resided in the room. CNA #3 indicated the resident changed his own briefs.</p> <p>There was a dried brown substance on the floor in room 311. There were two residents who resided in the room (one was in the hospital). The D-Wing Unit Manager indicated it looked like dirt.</p> <p>There was a dried substance on the over bed table, the room wall had cracked plaster, the over the toilet commode was rusty with a dried brown substance on the back of the toilet seat, and the plaster was bubbled in the bathroom of room 317. There were two residents who resided in the room. The D-Wing Unit Manager indicated she did not know what the dried substance was on the over bed table.</p> <p>There was dried substance on the over bed table for the window bed in room 322. There were two residents who resided in the room.</p>		<p>effected rooms and all deficient plaster was repaired.</p> <p>All residents have the potential to be effected by deficient plaster. DCE will perform in-service for floor staff and ACE Round Members in an effort to educate them on putting any aesthetic room issues into Building Engines Program. This input into the program will in turn create a work order for Maintenance.</p> <p>A line item will be added to Daily Interior & Inspection Form to identify any plaster issues with walls (please see attachment).</p> <p>Maintenance Supervisor will daily monitor the inspection sheets and work orders for any identified issues. Findings will be reported during QA&A for 6 months.</p> <p>Date of compliance: September 26th, 2014</p> <p>F465</p> <p>Regarding Housekeeping: All 14 rooms identified were cleaned immediately.</p> <p>All residents are at risk of potential spills on the floor and dirty bedside tables. 33 residents are at risk for potential dirty floor mats. Housekeeping Supervisor will give an in-service on a greater focus to floor and floor mat cleanliness and</p>	

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	<p>The bathroom in room 327 had gouges out of the tile. There were two residents who resided in the room.</p> <p>There was a dried substance on the over bed table in room 330. There were 2 residents who resided in the room.</p> <p>There was a dried substance on the over bed table in room 331 and gouges out of the floor tile. The D-Wing Unit Manager acknowledged the dried substance and gouges. there were two residents who resided in the room.</p> <p>3. During an observation on 08/26/14 at 10:29 a.m., there was a dark liquid substance spilled on the floor in room 209. One resident resided in the room.</p> <p>During an observation on 08/26/14 at 12:52 p.m. the spilled dark liquid on the floor was now dried on the floor.</p> <p>During an observation on 08/26/14 at 3:26 p.m., the spilled dark liquid was no longer on the floor.</p> <p>4. During an observation on 08/26/14 at 11:27 a.m., there was a dried food substance on the side and lower bars of the wheelchair in room 334. There were two residents who resided in the room.</p>		<p>the appropriate cleaning of bedside tables.</p> <p>Two line items were added to the Daily Project Sheet (please see attached) that identifies a specific focus to clean floors and clean floor mats and bedside tables.</p> <p>The Housekeeping Supervisor will monitor daily forms to assess compliance. The line items will be a continuum of work. The findings will be brought to QA&A for 6 months.</p> <p>Date of compliance: September 26th, 2014</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F000507 SS=D	<p>During an interview on 08/26/14 at 2:14 p.m., the Assistant Director of Nursing indicated the wheelchairs are cleaned by the midnight CNA's on the resident shower days and should be cleaned as needed.</p> <p>A, "Scope of Services", received from the Administrator as current on 08/26/14 at 2:28 p.m., indicated resident rooms and restrooms are to be cleaned and sanitized daily.</p> <p>This Federal Tag relates to complaint IN00154838.</p> <p>3.1-19(f)</p> <p>483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Based on record review and interview, the facility failed to ensure an urinary culture and sensitivity (C&S) result was</p>	F000507	F507 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	09/26/2014

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	<p>received and filed in the resident's clinical record, for 1 of 4 residents reviewed for urinary tract infections (UTI), in a total sample of 7. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's record was reviewed on 08/26/14 at 10:39 a.m. The resident's diagnoses included, but were not related to, incomplete bladder emptying and convulsions.</p> <p>A Physician's Order, dated 08/16/14, indicated an order for a urinalysis (UA) and C&S (culture and sensitivity).</p> <p>A Progress note, dated 08/17/14 at 9:03 p.m., indicated the urine specimen had been obtained.</p> <p>There was a lack of documentation in the resident's record to indicate the urine C&S result had been received by the facility.</p> <p>During an interview on 08/26/14 at 11:03 a.m., LPN #2 indicated the facility had not received the results of the urine C&S. She indicated the laboratory company was faxing the results to the facility.</p> <p>Review of the urine C&S results,</p>		<p>The final c&s for resident D was notified on 8/26/14 and a new order for antibiotic therapy was obtained. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Other residents with u/a c&s ordered have the potential to be affected. Facility reviewed residents with orders over the past 14 days to ensure final c&s was obtained and resident was receiving an appropriate antibiotic. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nurses were re-educated on Lab Processing/Tracking Guideline and Diagnostic Tracking form. Nurses were re-educated on contacting lab for any reports that have not been received. Nurse competency was evaluated with a post education Quiz. Nurses will complete the Diagnostic Tracking form each time they receive an order for a u/a c&s. This form will be reviewed by each shift and updated until the final c&s is received and the MD is notified. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put</p>		

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	<p>received 08/26/14 at 11:23 a.m., indicated the resident had >100,000 colonies per milliliter of Proteus mirabilis and the Ciprofloxacin (Cipro) was more than two resistant to the organism.</p> <p>During an interview on 08/26/14 at 11:18 a.m., the D-Wing Unit Manager indicated an urine C&S result should be returned to the facility within 48 hours. She indicated it was everyone's responsibility to ensure the facility received the results.</p> <p>During a telephone interview on 08/26/14 at 11:34 A.M., the laboratory company indicated they had faxed the preliminary C&S results to the facility on 08/19/14 at 11:32 a.m. and the final results were faxed to the facility on 08/20/14 at 11:34 a.m. She indicated the results are not faxed to the Physician, only to the facility.</p> <p>During an interview on 08/27/14 at 9:35 a.m., the Director of Nursing indicated the facility had not found the C&S results faxed to the facility from the laboratory company.</p> <p>This Federal Tag relates to complaint IN00154838.</p> <p>3.1-49(f)(4)</p>		<p>into place. Unit managers will bring Diagnostic Tracking form to Clinical start up 5x weekly for review by the DNS to ensure the deficient practice does not recur. Results will be brought to QAPI monthly for a minimum of 6 months by the DNS or designee By what date the systemic changes will be completed? 9/26/14</p>	

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

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