

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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F000000	<p>This visit was for Investigation of Complaint IN00151336.</p> <p>Complaint IN00151336-Substantiated. Federal/State deficiencies related to the allegations are cited at F315.</p> <p>Survey dates: June 30, July 1 and 2, 2014</p> <p>Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980</p> <p>Survey team: Yolanda Love, RN-TC</p> <p>Census bed type: SNF/NF: 159 Total: 159</p> <p>Census payor type: Medicare: 20 Medicaid: 126 Other: 13 Total: 159</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 6, 2014, by Janelyn Kulik, RN.</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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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE 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 ensure each resident with an indwelling foley catheter and diagnosed with an urinary tract infection (UTI) was treated as ordered by the Physician for 1 of 3 residents reviewed for UTI's. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 7/1/14 at 8:40 a.m. The resident's diagnoses included, but were not limited to, history of UTI's, cerebrovascular disease, hydrocephalus, aphasia and dysphasia.</p>	F000315	<p>This Plan of Correction constitutes the facility's written allegation of compliance for the deficit sited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.</p> <p>The facility, Golden Living Center-Fountainview Place, respectfully requests consideration of this Plan of Correction to be granted paper compliance.</p> <p>F 315 The corrective action(s) that were accomplished for the resident</p>	07/18/2014

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	<p>Review of the Nursing progress notes dated 2/7/14 indicated the resident was admitted to the facility at 5:25 p.m., and had an indwelling foley catheter draining yellow urine. Further review of the Nursing progress notes indicated, on 2/8/14 the resident was assessed. The resident was flushed and clammy with a temperature reading of 101.2. The resident was treated with an as needed dose of Tylenol to decrease the temperature which was not effective. The Physician was then notified and an order was obtained to transfer the resident to the Emergency Room (ER) for evaluation and treatment. The resident was transferred from the facility at 10:00 a.m.</p> <p>Continued review of the Nursing progress notes indicated the resident returned to the facility on 2/8/14 at 4:19 p.m. The resident was alert and responsive and her foley was draining clear yellow urine. The facility received new orders from the ER Physician for sulfamethoxazole/trimethoprim (antibiotics that treat different types of infection caused by bacteria) 800-160 milligrams (mg) oral tablets, to be administered every 12 hours for 2 weeks for the treatment of an UTI.</p> <p>Review of the facility 's Physician telephone order dated 2/8/14 indicated,</p>		<p>found to have been affected by the deficient practice: A complete chart review for Resident #B was done on 7/11/2014 to include verification of all ordered medications and that pharmacy orders were entered correctly.</p> <p>Other Residents having the potential to be affected by the same deficient practice were identified and corrective action was taken: An audit of all residents receiving antibiotic therapy was conducted to verify that the order in the computer, the MAR, and the pharmacy orders all matched the original physician orders for the antibiotic. No other problems were noted during this audit.</p> <p>Measures that were put in place to affect a systemic change to make sure that the deficient practice does not recur: All new orders for medications will be reviewed by the nursing management team during Morning Start Up Meeting on Monday-Friday. The medication orders that were written since the last Morning Start Up Meeting will be verified in the pharmacy/MAR system to insure that they match the original physician order. If a discrepancy is found, the error will be corrected immediately by the nursing management team members.</p> <p>The corrective action will be monitored to insure that the deficient practice does not recur</p>		

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	<p>sulfamethoxazole/trimethoprim give 800-160 mg by mouth 2 times a day for UTI related to neurogenic bladder until 2/9/14.</p> <p>Review of the 2/2014 Medication Administration Record (MAR) indicated the resident had only received 2 doses of the medication on 2/9/14.</p> <p>Interview with the C Hall unit manager on 7/1/13 at 2:00 p.m., indicated there was a medication error related to the duration of the medication and the resident had only received 2 doses of the prescribed antibiotic.</p> <p>This Federal tag relates to complaint IN00151336. 3.1-41(a)(2)</p>		<p>via a quality assurance program: The process of monitoring medication orders at the Morning Start Up Meeting will be monitored weekly for 4 weeks, monthly for 3 months, and then quarterly for two quarters. The results of the monitoring will be reported to the facility QAPI committee.</p> <p>The date the systemic change will be completed: July 18, 2014</p>		