

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155120	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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F000000	<p>This visit was for the Investigation of Complaint IN00148417.</p> <p>Complaint IN00148417 - Substantiated. Federal and state deficiencies related to the allegations are cited at F274, F279 and F282.</p> <p>Survey dates: May 9, 12 and 13, 2014</p> <p>Facility number: 000050 Provider number: 155120 AIM number: 100266170</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 124 Total: 124</p> <p>Census payor type: Medicare: 14 Medicaid: 89 Other: 21 Total: 124</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 14,</p>	F000000		

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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F000274 SS=D	<p>2014 by Cheryl Fielden, RN.</p> <p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on interview and record review, the facility failed to ensure the accuracy of a significant change reassessment regarding the initiation of hemodialysis services for 1 of 3 residents reviewed for hemodialysis in a sample of 3. (Resident #C)</p> <p>Findings include:  Resident #C's clinical record was reviewed on 5-13-14 at 9:30 a.m. His diagnoses included, but were not limited to, end stage renal (ESRD), high blood</p>	F000274	<p>To accomplish corrective actions for residents affected by the practice, the MDS for Resident "C" was modified to properly code the dialysis, locked, transmitted and accepted on 05/16/2014.</p> <p>To identify other residents having the potential to be affected by the practice the MDS's for all other Residents receiving dialysis were reviewed and found to be coded correctly</p> <p>To ensure that the practice does not recur, MDS RN #1 and MDS RN #2 have been re-instructed by the DNS</p>	06/06/2014

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	<p>pressure, coronary artery disease, cerebrovascular disease (stroke) and atrial fibrillation (irregular heart rhythm). The clinical record indicated Resident #C returned from a hospitalization to the facility on 4-3-14 with physician orders for hemodialysis three times weekly. The clinical record indicated he had not previously been receiving hemodialysis services prior to the hospitalization. The clinical record indicated he began receiving hemodialysis services, as ordered, upon return to the facility.</p> <p>Review of the admission Minimum Data Set (MDS) assessment, dated 2-5-14, indicated he did not receive dialysis services. A significant change MDS assessment, dated 4-10-14, indicated he did not receive dialysis services.</p> <p>In interview with MDS Staff #1 on 5-13-14 at 1:45 p.m., she indicated she did not complete the significant change MDS assessment, dated 4-10-14, for Resident #C. She indicated she thought the reason for the significant change MDS assessment was due to the resident beginning dialysis services.</p> <p>In interview with MDS Staff #2 on 5-13-14 at 2:15 p.m., she indicated she completed the significant change MDS assessment, dated 4-10-14, for Resident</p>		<p>regarding the importance of accuracy in coding the MDS assessment for all residents. Additionally, the MDS RNs will be auditing each others MDS to ensure accuracy of coding in Section O. Any issue identified on the audit will be corrected immediately prior to locking and transmitting the assessment.</p> <p>To monitor the changes in practice and ensure that the practice does not recur, the MDS RN will bring the results of the audits to the monthly QAPI meetings for at least the next 6 meetings for review. Any trends will be analyzed determine the need to Action Plan the item for ongoing compliance.</p>		

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F000279 SS=D	<p>#C. She indicated, "It looks like I missed the Section O portion on dialysis. I can't remember why, but it looks like I did. I will make sure it gets corrected."</p> <p>On 5-13-14 at 2:50 p.m., the Executive Director provided a copy of a policy entitled, "Section O: Special Treatments, Procedures, and Programs." This policy was indicated to be a part of the CMS (Centers for Medicare and Medicaid Services) MDS Manual, version 3.0. It indicated, under subheading O0100J, Dialysis, "Code peritoneal or renal dialysis that occurs at the nursing home or another facility in this item."</p> <p>This Federal tag relates to Complaint IN00148417.</p> <p>3.1-31(d)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services</p>						

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	<p>that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a plan of care that accurately reflected a resident's renal (kidney) function problems of current fluid restriction status and newly initiated treatment of hemodialysis for 1 of 3 residents reviewed for hemodialysis in a sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's clinical record was reviewed on 5-13-14 at 9:30 a.m. His diagnoses included, but were not limited to, end stage renal disease, high blood pressure, coronary artery disease, cerebrovascular disease (stroke) and atrial fibrillation (irregular heart rhythm). The clinical record indicated Resident #C returned from a hospitalization to the facility on 4-3-14 with physician orders for hemodialysis three times weekly. The clinical record indicated he had not previously been receiving hemodialysis services prior to the hospitalization.</p> <p>On 5-9-14 at 2:00 p.m., the Executive</p>	F000279	<p>To accomplish corrective actions for residents affected by the practice, the care plan was updated to adequately reflect that Resident "C" was receiving hemodialysis, its frequency, and that the fluid restriction was removed on 05/13/2014.</p> <p>To identify other residents having the potential to be affected by the practice, the care plans for all residents receiving special services of dialysis have been reviewed and updated as indicated.</p> <p>To ensure that the practice does not recur, MDS RN #1 and MDS RN #2 have been re-instructed by the DNS regarding the importance of accuracy in developing the Care Plan for all residents. Additionally, the MDS RNs will be auditing each others Care Plans to ensure accuracy of the plan of care. Any issue identified on the audit will be corrected immediately.</p> <p>To monitor the changes in practice and ensure that the deficient practice does not recur, the MDS RN will bring the results of the audits to the</p>	06/06/2014

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	<p>Director (ED) provided a listing of current residents receiving hemodialysis services. Resident #C was included on this listing.</p> <p>In review of Resident #C's care plans, a "focus" (concern or problem) was identified as "Alteration in Kidney Function Due to End Stage Renal Disease (ESRD), evidenced by hemodialysis. Permacath right upper chest." This concern was indicated as initiated on 4-4-14. In review of the interventions for this focus, nothing was indicated as to the resident actually receiving hemodialysis services or the frequency of the service. An intervention listed indicated, "Written communication form with review of weights and any changes in condition between dialysis provider and living center."</p> <p>In an interview with MDS Staff #1 on 5-13-14 at 1:45 p.m., she indicated the care plan should indicate something specific to receiving hemodialysis services as ordered by the physician and she did not see that present.</p> <p>In review of Resident #C's physician orders, an order was written on 4-4-14 for a fluid restriction of 1500 milliliters (ml) of fluid for each 24 hour period for Resident #C. This order was clarified on</p>		<p>Clinical Startup meeting Monday through Friday for one month and to the monthly QAPI meetings for at least the next 6 months for review. Any trends will be analyzed determine the need to Action Plan the item for ongoing compliance.</p>		

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	<p>4-14-14 and discontinued on 4-22-13.</p> <p>In review of the focus (concern or problem) identified as, "Alteration in elimination of bowel and bladder: Occasional Bladder Incontinence. Dx. [diagnosis] of Chronic Kidney Disease, Constipation. Receives limited fluids r/t [related to] ESRD; receives routine diuretic." This focus was indicated to have been initiated on 2-17-14. The interventions for this focus was indicated to include a 1500 ml fluid restriction daily. This intervention was indicated to have been revised/reviewed on 4-21-14. No further documentation was indicated to address this fluid restriction was no longer in effect.</p> <p>In interview with MDS Staff #1 on 5-13-14 at 1:45 p.m., she indicated she had discontinued a care plan specific to the fluid restriction under the heading of nutrition, but did not do so for the fluid restriction intervention listed under the heading of elimination. She indicated she had missed that particular intervention to discontinue, but should have done so.</p> <p>On 5-13-14 at 3:15 p.m., the Director of Nursing provided a copy of a policy entitled, "Care Plan." This policy indicated, "An interdisciplinary approach</p>			

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F000282 SS=D	<p>to identification of problems and developing solutions provides individualization and coordination of resident care. All residents must have a care plan...The interdisciplinary care plan is reviewed, revised and updated quarterly and more frequently if warranted by a change in resident's condition..." This policy had an effective date of May 2001 and was indicated to be the current policy in effect.</p> <p>This Federal tag relates to Complaint IN00148417.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 interview and record review, the facility failed to ensure physician ordered follow up medical appointments were completed in a timely manner for 2 of 3 residents reviewed for adherence to physician orders in a sample of 3. (Resident #A and Resident #B)</p>	F000282	<p>To accomplish corrective actions for residents affected by the practice, the identified appointment was rescheduled.</p> <p>To identify other residents having the potential to be affected by the practice, all records have been reviewed to ensure that no additional appointments are at risk of being "no</p>	06/06/2014

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	<p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 5-12-14 at 9:25 a.m. Her diagnoses included, but were not limited to, end-stage renal disease (ESRD) with hemodialysis, diabetes, fracture of the distal end of the tibia (ankle area), coronary artery disease, peripheral vascular disease, high blood pressure and history of myocardial infarction (heart attack).</p> <p>Review of Resident #A's clinical record indicated she was admitted to the facility on 2-18-14 after a hospitalization for surgical repair of a fracture of the distal end of the tibia as a result of a fall at home. The discharge notes from the orthopedic surgeon, dated 2-17-14, indicated to schedule a follow up appointment with the orthopedic surgeon in 2 weeks. This notation included the physician's office phone number to schedule the appointment.</p> <p>In interview with RN #1 on 5-12-14 at 11:00 a.m., he indicated the follow up appointment ordered with the initial discharge orders from the hospital, dated 2-18-14, were missed by the facility staff. He indicated the follow up appointment with the orthopedic surgeon was for a 2 week follow up and ended up not getting</p>		<p>show".</p> <p>To ensure that the practice does not recur, the DNS and designee will retrain nurses by May 31, 2014 on using the Point Click Care system to enter and track appointments. The training for nurses direct them to include time, specific physician, specific office location, phone number, and transportation arranged in the PCC order. Additionally they will enter the appointment information on the paper calendar located on the unit desk. The Unit Coordinators will review the calendar and the PCC report Monday through Friday to verify accuracy of these appointments as compared to the documents returned with the resident taking any corrective steps as indicated.</p> <p>To monitor the changes in practice and ensure that the practice does not recur, the report from Point Click Care for scheduled appointments will be reviewed by the DNS or designee daily Monday through Friday during the Morning Communication Meeting to monitor upcoming appointments. Any omissions will be resolved immediately holding the Unit Coordinator accountable for accuracy. This practice will be ongoing and reviewed at the monthly QAPI meeting for a minimum of 6 months.</p>				

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	<p>scheduled until 4-1-14, approximately 4 weeks later than ordered. He indicated, "This ended up causing the cast to stay on for about 6 weeks, instead of what the family was told would be about 4 weeks. She ended up with some skin problems that might have been caused by the cast." RN #1 indicated the resident had been re-hospitalized during this time (from 3-13-14 to 3-18-14). He indicated the facility assumed the orthopedic surgeon would have seen her during this hospitalization to care for the cast. He indicated the orthopedic surgeon was upset with the facility regarding the cast being in place for an extended period of time.</p> <p>Review of an office visit with the orthopedic surgeon on 4-17-14 indicated instructions for a follow up visit to be evaluated by a particular physician by name. It did not include the physician's contact information, only the physician's last name and the reason cited was "for wound coverage." The clinical record indicated the resident was currently being followed by a local wound center.</p> <p>In an interview with RN #1 on 5-12-14 at 3:10 p.m., he indicated LPN #4 had received a phone call from the orthopedic surgeon's nurse to refer the resident to wound center physician. He indicated the</p>			

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	<p>surgeon's nurse did not inform LPN #4 this particular physician was also a plastic surgeon. He indicated LPN #4 shared with him this was confusing as the resident was already being seen by the local wound center. He indicated a facility staff person spoke with the plastic surgeon's office to reschedule the appointment date to a non-dialysis date of 4-24-14. RN #1 indicated he recalled speaking with the surgeon's nurse regarding the appointment with the plastic surgeon for 4-24-14. He indicated that he normally is the person for Resident #A's unit that schedules appointments and corresponding transportation. RN #1 indicated he could not find the 4-24-14 appointment date on the unit's calendar used for appointments. He indicated he had no idea why it was not on the calendar.</p> <p>In an interview with office staff of the plastic surgeon on 5-12-14 at 2:20 p.m., she indicated RN #1 confirmed Resident #A's appointment by phone on 4-17-14 or 4-18-14 for an appointment on 4-24-14. She indicated the resident was a "no show" for that appointment. She indicated the resident was rescheduled for 5-1-14 and did attend that appointment.</p> <p>No documentation was located in the</p>			

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	<p>clinical record regarding the scheduling or rescheduling of appointments for Resident #A for the 4-24-14 or 5-1-14 appointments.</p> <p>2. Resident #C's clinical record was reviewed on 5-13-14 at 9:30 a.m. His diagnoses included, but were not limited to, end stage renal disease (ESRD), high blood pressure, coronary artery disease, cerebrovascular disease (stroke) and atrial fibrillation (irregular heart rhythm). It indicated he was readmitted to the facility on 4-3-14 after a hospitalization related to ESRD.</p> <p>Review of Resident #C's hospital discharge orders, dated 4-3-14, indicated he was to have a follow up visit on 4-25-14 at 2:20 p.m. with a cardiovascular physician. This documentation included the physician's contact information of name, address and phone number. A handwritten notation beside the contact information indicated, "May 1st. 1:30. North."</p> <p>In an interview with RN #1 on 5-13-14 at 11:40 a.m., he indicated Resident #C was scheduled for an appointment with the cardiovascular physician on 5-1-14. He indicated there was some type of a mix up and the ambulance service did not get the resident picked up for the</p>			

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	<p>appointment. He indicated the nurse on duty did call to reschedule the appointment, but was told by the office staff the resident did not have an appointment scheduled for 5-1-14. He indicated the staff nurse apparently called the wrong office number. The appointment was not rescheduled. RN #1 indicated that he called the cardiovascular physician's office today and was told the resident had in fact missed the 5-1-14 appointment at the north office. He indicated he rescheduled the appointment for 6-9-14. RN #1 indicated he could not find any documentation in Resident #C's clinical record regarding the missed appointment or attempt to reschedule the appointment.</p> <p>In an interview with the Assistant Director of Nursing on 5-12-14 at 2:10 p.m., she indicated the facility had identified a concern related to missed appointments in regard to Resident #A, as of 4-7-14, and were actively working on this issue to correct it.</p> <p>This Federal tag relates to Complaint IN00148417.</p> <p>3.1-35(g)(2)</p>				