

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 01/19/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN46368
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F0000	<p>This visit was for the Investigation of Complaint IN00102420 and Complaint IN00102434.</p> <p>Complaint IN00102420 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282.</p> <p>Complaint IN00102434 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: January 17, 18 &amp; 19, 2012</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Survey team; Kathleen (Kitty) Vargas, RN, TC</p> <p>Census bed type: SNF/NF: 170 Total: 170</p> <p>Census payor type: Medicare: 28 Medicaid: 130 Other: 12 Total: 170</p>	F0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or argeement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

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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F0223 SS=A	<p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/19/12 by Suzanne Williams, RN</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from verbal and physical abuse, for 1 of 3 allegations of abuse reviewed in a sample of 8. (Resident #H)</p> <p>Findings include:</p> <p>The Facility's State Reportables for allegations of abuse were reviewed on 1/18/12 at 11:00 a.m. There was an allegation of an alleged verbal and physical abuse on 12/9/11 between Resident #H and CNA #1.</p> <p>The Report of Incident dated 12/9/2011, was reviewed. It indicated: Brief Description of Incident: Alleged abuse towards a resident. CNA allegedly placed</p>	F0223	<p>Resident H has been discharged to her home. Employee #1 was terminated after internal investigation of the allegation. All residents have the potential to be affected by abuse. After the internal investigation staff were re-educated on "Abuse of the Elderly." No other residents were identified as being abused by employee #1 or any other employee. Staff re-education on abuse prevention and reporting. Employees are completing post tests and are required to pass at 80% or above. Any employee without a passing score will be provided further education. Members of the management team will interview residents/families, and staff utilizing the QIS interview questions regarding abuse. Twenty Interviews will be</p>	01/31/2012

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	<p>her hand over the resident's mouth and pinned her arms to her side during care. Resident is combative and resistive to care. She hits, spits, and kicks during routine care.</p> <p>The alleged abuse was against CNA #1. It indicated CNA #1 placed her hand over resident #H's mouth and pinned her arms to her side during care.</p> <p>Student CNA #1 wrote a statement on 12/9/11 that indicated, "On December 9, 2011, I accompanied (CNA #1's name) in a resident room to assist her with the resident. The resident reacted violently by hitting her and spitting on (CNA #1's name). So (CNA #1's name) reacted by putting tissue over her mouth and pressing her hand forcibly over the resident mouth while also forcibly pinning her arms down (sic). She told me to hurry up and put the brief on and also stated that if the resident hit her she would hit her a __ back."</p> <p>The Student CNA #1 reported the event to her instructor. The instructor reported the event to the Executive Director and Assistant Director of Nursing.</p> <p>The Follow-Up report dated 12/9/11 indicated: Immediate action taken: CNA #1 was removed from the unit and placed in a non-patient care area. CNA #1 was</p>		<p>conducted weekly times 4 weeks and then a 10% sample will be interviewed monthly. The ED and The DENS will review interviews and report Monthly to the QAA Committee on any allegations of abuse and the findings.</p>		

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	<p>interviewed and then suspended pending investigation. An assessment of the resident was completed and no bruises or marks were noted to the skin, the resident did not exhibit any pain or fear of staff. The physician was notified. Staff left a message for the husband. The investigation found the allegations were correct and CNA #1 felt that she was defending herself and did not realize the seriousness of her actions. Other residents were interviewed and no one felt that the CNA in question was inappropriate with their care.</p> <p>Preventative measures taken: CNA#1 was terminated, and staff were inserviced on all forms of abuse, verbal, physical and mental.</p> <p>Review of Resident #H's record on 1/19/12 at 8:00 a.m., indicated the resident had diagnoses that included, but were not limited to, dementia, hypertension and psychosis. The care plan dated 11/22/11 indicated, "I sometimes spit at others and hit staff, I kicked and spit at other residents."</p> <p>Interview with the Executive Director on 1/18/12 at 4:10 p.m., indicated the allegation of abuse involving Resident #H and CNA #1 was substantiated. He also indicated the CNA was terminated.</p>				

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F0282 SS=D	<p>3.1-27(b)</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 record review and interview, the facility failed to ensure physician orders were followed related the administration of simvastatin, a cholesterol lowering medication, for 1 of 8 residents reviewed for physician orders in a sample of 8. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 1/17/12 at 2:00 p.m. The resident had diagnoses that included, but were not limited to, diabetes, hypertension and Alzheimer's disease.</p> <p>Review of the December 2011 Medication Administration Record (MAR) indicated the resident was receiving simvastatin 80 milligrams (mg) orally every hs (hour of sleep). The MAR indicated the hour of administration was 1900 (7:00 p.m.). The resident received the medication at 7:00 p.m. from 12/1/11 through 12/28/11. The medication was discontinued on 12/29/11.</p> <p>There was a physician order dated</p>	F0282	<p>The medication order for Resident B has been rewritten to reflect the correct medication time. All residents have the potential to be affected by the same deficient practice. A full house audit of all medication orders and administration times will be completed by 1/31/2012. Any discrepancies found will be clarified with the MD and clarification orders and administration records implemented. Nurese re-education on physicians orders and ensuring administration time matches physician order to be completed by 1/31/2012. A nursing supervisor will review new 2 orders on a daily basis to ensure physician orders and administration times are implemented as ordered. DNS or her designee will review all new orders weekly tomes 4 weeks for any irregularities. DNS or her designee will randomly audit orders monthly. DNS or her designee will report any findings to QAA Committee for possible action plan if any trends of significance are found. Audit and changes will be completed by 1/31/2012.</p>	01/31/2012	

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	<p>12/29/11 that indicated simvastatin was to be reduced to 40 milligrams every hs (hour of sleep).</p> <p>Review of the January 2012 Medication Administration Record indicated the simvastatin 40 mg was to be given at hs. The hour of administration was written as 0800 (8:00 a.m.). The simvastatin 40 mg was administered to the resident at 8:00 a.m. during the month of January 2012.</p> <p>Interview with LPN #1 on 1/17/12 at 2:35 p.m., indicated she had administered the simvastatin to the resident at 8:00 a.m. that morning. She indicated that the physician's order was to administer the medication at the hour of sleep. She indicated the medication was administered incorrectly during the month of January 2012. She indicated the medication should have been given in the evening as ordered by the physician.</p> <p>This Federal tag relates to Complaint IN00102420.</p> <p>3.1-35(g)(2)</p>				