

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 07/19/2013
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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 Recertification and State Licensure Survey. This visit also included the investigation of Complaint IN00132145.</p> <p>Complaint IN00132145-Substantiated. No deficiencies are cited related to the allegation.</p> <p>Survey dates: July 15 to 19, 2013</p> <p>Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. Cynthia Stramel, R.N. Caitlyn Doyle, R.N. Heather Hite, R.N. Sharon Ewing, R.N.</p> <p>Census Bed Type: SNF/NF:153 Total: 153</p> <p>Census Payor Type: Medicare: 20 Medicaid: 127 Other: 6 Total: 153</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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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 25, 2013, by Janelyn Kulik, RN.</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each residents' dignity was maintained during dining related to residents being called "hun" and "baby" for 1 of 1 dining observations on 2 of 4 wings throughout the facility. This had the potential to affect 2 of 55 residents residing on the B Wing and 1 of 34 residents residing on the E Wing. (Residents #132, #180, and #196)</p> <p>Findings include:</p> <p>1. On 7/15/13 at 12:02 p.m., during the lunch meal in the E Wing dining room, the following was observed: CNA #1 called Resident #196 "hun" while passing beverages.</p> <p>Interview with the Director of the E Wing on 7/19/13 at 2:30 p.m., indicated the residents should be addressed by their first name not "hun".</p>	F000241	<p>The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Residents #196, #180 and #132 were affected by this alleged deficient practice. The facility was unable to correct the alleged deficient practice for these residents. All residents have the potential to be affected by this deficient practice. All facility staff will be re-in-serviced by 8-18-13 on the proper way to maintain a resident's dignity by addressing them by using their proper names instead of addressing them using other unacceptable references such as "hun" and "baby". The facility DNS, Executive Director, or designee will develop and implement the use of a Resident Dignity Audit Tool. Audits will be conducted daily (5times per week) for 30 days, then weekly for 60 days, then monthly for an additional 90 days to ensure that all residents are treated with dignity and respect at all times. The results of these Resident Dignity Audit (see item #1) will be discussed at Daily</p>	08/18/2013	

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	<p>2. During lunch dining observation in the B Wing sunroom on 7/15/13 at 11:45 a.m. Resident #180 was observed sitting at the table with Unit Manager #2. Unit Manager #2 was assisting the resident with eating and said to the resident "grab your fork babe."</p> <p>Interview with Unit Manager #2 on 7/19/13 at 10:34 a.m., indicated referring to residents as "babe" and not by the resident's name was not acceptable.</p> <p>3. During lunch dining observation in the B Wing sunroom on 7/15/13 at 11:45 a.m. Resident #132 was observed attempting to propel her wheelchair out of the sunroom but her wheelchair brakes were locked. Unit</p>		<p>Stand Up meetings and then again at the facilities monthly QA&A meetings to ensure that our residents reside in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Audit findings will be reviewed in QA&A meetings for 6 months and thereafter decreased to an as needed basis as determined by the QA&A committee. Any patterns or trends that are identified will cause an Action Plan to be written and appropriate interventions to be implemented.</p>		

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	<p>Manager #2 approached the resident and said "you're locked babe."</p> <p>Interview with Unit Manager #2 on 7/19/13 at 10:34 a.m., indicated referring to residents as "babe" and not by the resident's name was not acceptable.</p> <p>3.1-3(t)</p>				

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F000279 SS=B	<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 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 record review and interview, the facility failed to ensure each resident had a care plan related to Activities of Daily Living and anticoagulant therapy for 1 of 2 residents reviewed for Activities of Daily Living of the 2 residents who met the criteria for Activities of Daily Living and for 1 of 10 residents reviewed for unnecessary medications. (Resident's #48 & #200)</p> <p>Findings include:</p> <p>1. Interview with Resident #200's</p>	F000279	The facility will use the results of the assessments to develop, review and revise the resident's comprehensive plan of care. Further, the facility will 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. Finally the facility will ensure that the care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	08/18/2013	

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	<p>family member on 7/16/13 at 9:37 a.m., indicated when he visits his mother, he notices she has food on her shirt. He further indicated he felt the facility staff do not assist his mother with meals and to use utensils rather than her fingers.</p> <p>The record for Resident #200 was reviewed on 7/16/13 at 3:00 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, closed fracture of humerus, senile dementia with depressive features, Alzheimer's disease, and depressive disorder.</p> <p>Review of the 5/28/13 quarterly Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented. The resident needed supervision with one person physical assist with eating.</p> <p>Review of an Occupational Therapy (OT) note dated 5/23/13 indicated the resident was referred to OT due to inappropriate feeding and social skill at meals. It was determined the resident would receive OT for establishing cognitive level of functioning.</p> <p>Review of a 6/13/13 OT progress note indicated the resident required</p>		<p>psychosocial will-being 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).Resident's #48 and #200 were affected by this alleged deficient practice. These residents care plans were reviewed and modified as necessary.All residents have the potential to be effected by this alleged deficient practice.All staff nurses will be re-in-serviced, by 8-18-13, on the proper procedure for developing comprehensive resident care plans.The facility DNS or designee will review all resident care plans with special focus on the areas of Activities of Daily Living, Anticoagulant therapy and unnecessary medications. Care Plans will be reviewed and modivied to ensure that the individual needs of each resident are being met.The facility DNS or designee will review residents' Care Plans as part of the facilities weekly care plan meetings and per the care planning schedule to ensure that all resident needs are addressed in a timely manner.All resident changes in condition, new MD orders and other clinical issues will be discussed as part of the Daily Stand Up meeting Resident Care Plans will be modified to meet each resident's ongoing medical, nursing, mental and</p>		

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	<p>46% cognitive assist to use utensils to complete meals during the breakfast meal and at the lunch meal. The resident required an increase in cognitive assist for using utensils to eat.</p> <p>On 6/18/13 the resident was discharged from OT with much improvement with utensil use and with improved manners. The resident still required cueing and assistance with meals with utensil use. The Nursing staff were educated on helping the resident and assist her at meals.</p> <p>Review of the current 7/2013 care plan indicated there was no plan of care for the resident's eating assistance and for the use of utensils during meals.</p> <p>Interview with the Special Care Unit Director on 7/18/13 at 10:43 a.m., indicated there was no care plan for the problem of the resident eating with her fingers rather than eating with utensils.</p> <p>2. The record for Resident #48 was reviewed on 7/17/13 at 7:15 a.m. The resident was admitted to the facility on 6/18/13 from the hospital.</p> <p>The resident's diagnoses included,</p>		<p>psychosocial needs that are identified by these care reviews. The facility Unit Managers, or designee will conduct a Weekly Care Plan Audit, using the Resident Care Plan Audit tool (see item #2). The audits will consist of a weekly audit of 10% of resident Care Plans for a period of 30 days, then a bi-weekly audit of 10% of all resident care plans for an additional 60 day period, then a monthly audit of 10% of resident care plans for a period of 90 days. All resident Care Plan Audit results will be reviewed by the DNS at the Daily Stand Up Meetings and at the facilities monthly QA&A meetings. Audit findings will be reviewed in QA&A meetings for a period of 6 months and thereafter decreased to an as needed basis as determined by the QA&A committee. Any patterns or trends that are identified will cause an Action Plan to be written and appropriate interventions to be implemented.</p>		

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	<p>but were not limited to, other skin conditions, high blood pressure, and ischemic heart disease.</p> <p>Review of the admission 6/18/13 Minimum Data Set (MDS) assessment indicated the resident was alert and oriented. The resident was receiving an anticoagulant medication (a medication used to thin the blood) seven days a week.</p> <p>Review of Physician's Orders dated 6/18/13 indicated Coumadin (anticoagulant medication) 1.5 milligrams (mg) daily.</p> <p>Review of the current plan of care dated 6/2013 indicated there was no care plan for the resident's Coumadin therapy.</p> <p>Interview with the MDS Coordinator on 7/17/13 at 11:45 a.m., indicated there should have been a care plan for monitoring the resident while receiving an anticoagulant medication.</p> <p>3.1-35(a)</p>				

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F000282 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, record review, and interview, the facility failed to ensure the resident's care plan was followed related to monitoring bruises and administering insulin per Physician's Order for 1 of 3 resident's reviewed for non pressure related skin conditions of the 4 residents who met the criteria for non pressure related skin conditions and for 1 of 10 residents reviewed for unnecessary medications. (Resident #48 & #197)</p> <p>Findings include:</p> <p>On 7/15/13 at 11:52 a.m. Resident #48 was observed with discolored red/purple areas to the back of his hands.</p> <p>On 7/16/13 at 2:50 p.m., the resident was observed with discolored red/purple areas to the back of his hands.</p> <p>On 7/17/13 at 6:30 a.m., and 8:00 a.m., the resident was observed with discolored red/purple areas to the back of his hands.</p>	F000282	<p>The facility will ensure that services provided or arranged by the facility for resident use are provided by qualified persons in accordance with each resident's written plan of care. Residents #48 and #197 were affected by this alleged deficient practice. The facility was unable to correct the alleged deficient practice for resident's #47 and #197. All residents have the potential to be effected by this deficient practice. All resident care plans were reviewed with special focus on insulin dependent diabetics and those residents on anti-coagulation therapy. Care plans were modified as necessary as part of this review. The facility staff nurses will be re-in-serviced by 8-18-13 on the proper procedure for the completion of resident assessments for Non-pressure related skin conditions and the facility policy related to the frequency with which these assessments are to be conducted. The staff nurses will also be re-in-serviced by 8-18-13 on facility policy regarding use of sliding scale insulin as ordered by a physician and the proper administration of insulin as it relates to sliding scale</p>	08/18/2013	

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	<p>On 7/18/13 at 8:45 a.m., 1:00 p.m., and 2:45 p.m. the resident was observed with discolored red/purple areas to the back of his hands.</p> <p>The record for Resident #48 was reviewed on 7/17/13 at 7:15 a.m. The resident was admitted to the facility on 6/18/13 from the hospital. The resident's diagnoses included, but were not limited to, other skin conditions, dehydration, atrial fibrillation, myocardial infarction, high blood pressure, and chronic ischemic heart disease.</p> <p>Review of the 6/18/13 admission Minimum Data Set (MDS) assessment indicated the resident was alert and oriented and was receiving an anticoagulant medication (a medication that thins the blood) seven days a week.</p> <p>Review of the current 6/2013 care plan for bruising indicated the resident was admitted to the facility with bruises. The nursing approaches were to do a weekly skin assessment.</p> <p>Review of the clinical health status record dated 6/18/13 nursing assessment indicated the resident's</p>		<p>protocol. The facility DNS or designee will conduct weekly audits of Non-pressure related Skin Assessments (using the Non-Pressure Related Skin Assessment Audit Tool see item #3) for a period of 30 days; then bi-weekly audits of Non-pressure Related Skin Assessments for an additional period of 60 days and then a monthly audit will be conducted for an additional period of 90 days to ensure that all Non-Pressure Related Skin Assessments are being completed per facility policy and that resident needs are being met in a timely manner. The facility DNS or designee will conduct daily reviews of physician orders related to sliding scale insulin administration and review MAR's documents in order to ensure that residents are receiving the proper insulin doses for a period of 30 days using the REsident Insulin Administration Audit Tool (see item #4). Then weekly audits of Sliding Scale insulin orders and MAR's will be conducted for an additional period of 60 days. Finally, the DNS or designee will conduct monthly audits of sliding scale insulin MD orders and MAR's documentation for a period of 90 days to ensure that all residents are receiving their insulin medication per doctors' orders. All significant results from the Non-Pressure Related Skin and Sliding Scale Insulin Audits will be reviewed as part of the</p>	

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	<p>bruises were identified on 6/18/13 at the time of admission. The resident had multiple bruises to the left forearm, right back of hand and back of forearm.</p> <p>Review of the wound evaluation flow sheet dated 6/18/13 upon admission indicated there was one wound evaluation flow sheet for each bruise. Review of the wound flow sheet for the left forearm bruises indicated the last assessment was dated 7/5/13. There were no further assessments. Review of the wound flow sheet for the bruises on the right arm indicated the last documented assessment was on 7/5/13. There were no further assessments of those bruises.</p> <p>Interview with the Wound Nurse on 7/19/13 at 8:01 a.m., indicated she was measuring and monitoring the bruises (non pressure sores) for a while, but then nursing took it over so she has not measured or monitored them lately.</p> <p>Interview with the D-Wing Unit Manager on 7/19/13 at 8:30 a.m., indicated the bruises were to be measured and monitored weekly.</p> <p>2. The record for Resident #197 was</p>		<p>facilities Daily Stand Up Meeting to ensure that resident's needs are being promptly met. All Non-Pressure Related Audit results and Sliiding Scale Insulin Administration Audit results will be discussed as part of the facilities monthly QA&A meetings. Audit findings will be reviewed in QA&A meetings for a period of 6 months and thereafter decreased to an as needed basis as deter mined by the QA&A committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented..</p>		

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	<p>reviewed on 7/17/13 at 6:58 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, type II diabetes mellitus, hypertension, and anemia.</p> <p>Review of the Physician Recapitulation Orders dated June 2013, indicated an order for sliding scale (insulin given per blood glucose test result) Novolog (insulin) subcutaneous (under the skin) before meals, with the following doses: < (less than) 60= Call Physician 60-169=0 units 170-275=4 units 276-350=8 units 351-425=12 units 426-500=16 units 501 or > (greater than)=Call Physician</p> <p>The Medication Administration Record (MAR) dated June 2013, indicated the resident's blood glucose test result on 6/3/13 before dinner was 281 and no insulin was given, the resident's blood glucose test result on 6/5/13 before dinner was 412 and no insulin was given, and the resident's blood glucose test result on 6/17/13 before dinner was 333 and no insulin was given.</p> <p>The MAR dated July 2013 indicated</p>				

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	<p>the resident's blood glucose test result on 7/8/13 before lunch was 219 and no insulin was given, the resident's blood glucose test result on 7/12/13 before breakfast was 218 and no insulin was given, the resident's blood glucose test result on 7/12/13 before dinner was 453 and no insulin was given, the resident's blood glucose test result on 7/15/13 before dinner was 407 and no insulin was given, the resident's blood glucose test result on 7/16/13 before lunch was 314 and no insulin was given, and the resident's blood glucose test result on 7/16/13 before dinner was 344 and no insulin was given.</p> <p>Review of the current plan of care updated on 5/13/13 indicated the resident had the potential for glycemic reactions related to diabetes mellitus. The Nursing interventions included insulin per Physician Order.</p> <p>Interview with Unit Manager #1 on 7/18/13 at 10:30 a.m., indicated insulin should have been given according to the sliding scale and the insulin dose should have been documented on the MAR. She indicated the insulin dose may have been documented somewhere else on the MAR but was unable to find documentation to support this.</p>			

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	<p>Review of the Physician Recapitulation orders dated July 2013, indicated an order for Lantus (insulin) 14 units subcutaneous daily at bedtime, originally dated 7/8/13.</p> <p>Review of the MAR dated July 2013, indicated on 7/10/13 the resident was given 28 units of Lantus at bedtime.</p> <p>Interview with Unit Manager #1 on 7/18/13 at 10:30 a.m., indicated the incorrect dose of Lantus had been given.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided related to wheelchair positioning for 1 of 3 residents reviewed for positioning of the 3 residents who met the criteria for positioning. The facility also failed to ensure bruises were assessed and monitored for 1 of 3 residents reviewed for skin conditions non-pressure related of the 4 residents who met the criteria for skin conditions non-pressure related as well as not assessing for pain sign and symptoms for 1 of 10 residents reviewed for unnecessary medications. (Residents #48, #100, and #200)</p> <p>Findings include:</p> <p>1. On 7/15/13 at 11:41 a.m., Resident #100 was observed leaning to the left in her wheelchair. The resident then proceeded to lean her head on the dining room table.</p>	F000309	The facility will ensure that each resident receives and that the facility provides 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 care plan. Resident's #48, #100 and #200 were affected by this deficient practice. These residents care plans were reviewed and modified as necessary. All residents have the potential to be affected by this deficient practice. All resident Medical Records were reviewed. Any residents found to be lacking in any Non-Pressure Related Skin Assessments, Wheel Chair Positioning Assessments, or Resident Pain Assessments were re-assessed and appropriate action(s) taken to provide the necessary care. Facility Staff Nurses will be re-in-serviced by 8-18-13 on how to properly complete a Wheel-Chair Positioning Assessments, a Non-Pressure Related Skin Assessments and a Resident	08/18/2013	

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	<p>There was a cushion in the resident's wheelchair but no other positioning devices were observed.</p> <p>On 7/16/13 at 8:44 a.m., the resident would alternate between leaning to the left in her wheelchair and resting her head on the dining room table.</p> <p>On 7/17/13 at 1:25 p.m., the resident was seated in her wheelchair in the hallway outside of the dining room. The resident's eyes were closed and she was leaning to the right side.</p> <p>On 7/18/13 at 12:00 p.m., the resident was seated in her wheelchair and leaning to the right side.</p> <p>On 7/19/13 at 11:45 a.m., the resident was seated in her wheelchair. Her head was on the dining room table. When the resident would raise her head, she would lean to the right in her wheelchair.</p> <p>The record for Resident #100 was reviewed on 7/16/13 at 2:50 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular disease and disorders of ankle and foot joint.</p> <p>Review of the 4/26/13 annual Minimum Data Set (MDS)</p>		<p>Pain Assessment and the facility policies associated with the completion of each of these assessments. The facility DNS or designee will conduct weekly audits using the Resident Wheelchair Positioning Audit Tool (see item #5), resident Non-Pressure Related Skin Assessment Audit Tool (see item #3) and Resident Pain Assessment Audit Tool (see item #6) for a period of 30 days, then bi-weekly audits in these three areas for an additional period of 60 days and then monthly audits of these three areas for a final period of 90 days. All audit results for Wheel-chair Positioning Assessments, Non-Pressure Related Skin assessment, and Pain Assessments will be reviewed as part of the facilities Daily Stand Up Meeting in order to ensure that resident's needs are met in a timely manner. Any significant audit results will also be reviewed at the facilities Monthly QA&A meetings. Audit findings will be reviewed in QA&A meetings for a period of 6 months and thereafter decreased to an as needed basis as determined by the QA&A committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented.</p>		

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	<p>assessment, indicated the resident needed extensive assist with bed mobility and transfers.</p> <p>The plan of care dated 5/6/13, indicated the resident had a physical functioning deficit related to bilateral upper and lower extremity range of motion weakness. The interventions indicated the resident was to receive passive range of motion and rehab therapy services as needed.</p> <p>The Physical therapy discharge summary dated 2/20/13, indicated the resident's sitting balance was good/fair. Documentation indicated that she required contact guard physical assistance (CGA) to maintain balance.</p> <p>Interview with the Unit Manager on 7/19/13 at 11:55 a.m., indicated the resident can lean in her wheelchair at times. She indicated the resident received range of motion, however, she had not had a recent screen for positioning in the wheelchair.</p> <p>2. On 7/15/13 at 11:52 a.m. Resident #48 was observed with discolored red/purple areas to the back of his</p>						

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	<p>hands.</p> <p>On 7/16/13 at 2:50 p.m., the resident was observed with discolored red/purple areas to the back of his hands.</p> <p>On 7/17/13 at 6:30 a.m., and 8:00 a.m., the resident was observed with discolored red/purple areas to the back of his hands.</p> <p>On 7/18/13 at 8:45 a.m., 1:00 p.m., and 2:45 p.m. the resident was observed with discolored red/purple areas to the back of his hands.</p> <p>The record for Resident #48 was reviewed on 7/17/13 at 7:15 a.m. The resident was admitted to the facility on 6/18/13 from the hospital. The resident's diagnoses included, but were not limited to, other skin conditions, dehydration, atrial fibrillation, myocardial infarction, high blood pressure, and chronic ischemic heart disease.</p> <p>Review of the 6/18/13 admission Minimum Data Set (MDS) assessment indicated the resident was alert and oriented and was receiving an anticoagulant medication (a medication that thins the blood) seven days a week.</p>			

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	<p>Review of the current 6/2013 care plan for bruising indicated the resident was admitted to the facility with bruises. The nursing approaches were to do a weekly skin assessment.</p> <p>Review of the clinical health status record dated 6/18/13 nursing assessment indicated the resident's bruises were identified on 6/18/13 at the time of admission. The resident had multiple bruises to the left forearm, right back of hand and back of forearm.</p> <p>Review of the wound evaluation flow sheet dated 6/18/13 upon admission indicated there was one wound evaluation flow sheet for each bruise. Review of the wound flow sheet indicated the resident had multiple 0.1 centimeters (cm) by 0.1 cm bruises on his right hand.</p> <p>Review of the wound flow sheet for the left forearm bruises indicated the last assessment was dated 7/5/13. There were no further assessments. Review of the wound flow sheet for the bruises on the right arm indicated the last documented assessment was on 7/5/13. There were no further assessments of those bruises.</p>			

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	<p>Further review of the wound flow sheets indicated there was no flow sheet for the back of the left hand.</p> <p>Interview with LPN #2 on 7/18/13 at 2:10 p.m., indicated the flow sheets were supposed to be filled out weekly, but since it was not a pressure sore the information regarding wounds would not be completed. She did not know the policy regarding measuring the bruises weekly. She indicated they would monitor the bruise if they got larger. LPN #2 was unaware the resident had any new bruises to his left or right hand. She further indicated she would look at his skin and reassess the bruising when the resident returned from therapy.</p> <p>Interview with the D-Wing Unit Manager on 7/18/13 at 3:10 p.m., indicated she did not know if the bruises had to be measured weekly, but did indicate the bruises had to be monitored weekly on the flow sheets. She further indicated she was unaware the resident had any new bruises.</p> <p>Review of the wound evaluation flow sheets on 7/19/13 at 7:59 a.m., indicated the following new bruises</p>			
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	<p>that were assessed and documented by LPN #2 on 7/18/13:</p> <ol style="list-style-type: none"> 1. one bruise to top right hand 8.5 cm by 2 cm 2. one bruise between middle finger and pointer finger 2 cm by 1 cm 3. top of left hand dark purple 9 cm by 9 cm bruise 4. left pointer finger 2 cm by 1.5 cm bruise 5. left ring finger knuckle bruise 2 cm by .5 cm 6. right ring finger 3 cm by 1.5 cm bruise 7. right hand 4 cm by 7 cm bruise <p>Interview with Director of Nursing (DoN) on 7/18/13 at 4:10 p.m., indicated she could not find a policy specifically for non pressure related areas. She further indicated the resident's skin issues should match the wound flow sheet and be monitored and measured weekly.</p> <p>Interview with the Wound Nurse on 7/19/13 at 8:01 a.m., indicated she was measuring and monitoring the bruises (non pressure sores) for a while, but then nursing took it over so she has not measured or monitored them lately.</p> <p>Interview with the D-Wing Unit</p>			

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	<p>Manager on 7/19/13 at 8:30 a.m., indicated the bruises were to measured and monitored weekly.</p> <p>3. On 7/16/13 3:30 p.m., Resident #200 was observed in activities in the dining room, She was observed with a sling to her left arm.</p> <p>On 7/17/13 at 7:50 a.m., the resident was observed in bed. At that time, the other residents on the unit were observed to be in the dining room eating breakfast.</p> <p>On 7/17/13 at 8:30 a.m., the resident was still observed in bed.</p> <p>Interview with the Special Care Director, at that time, indicated the resident did not want to get up. She indicated the resident has the right to stay in bed, so they offered her breakfast in bed, but she refused.</p> <p>On 7/17/13 at 12:10 p.m., the resident was observed sitting in a wheelchair. The resident was dressed and she was noted to have her left arm in a sling that was around her shoulder area.</p> <p>On 7/18/13 at 8:59 a.m., the resident was observed in bed, with her eyes closed. The resident was still</p>			

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	<p>dressed in her night clothes.</p> <p>Interview with LPN #3 on 7/18/13 at 9:00 a.m., indicated she was the regular nurse during the day shift. She indicated for the past couple of days the resident has not been wanting to get out of bed to eat breakfast. She indicated the resident did not get up for breakfast again today. She further indicated this was a new behavior for her. The LPN indicated once the resident gets out of bed she is "fine".</p> <p>The record for Resident #200 was reviewed on 7/16/13 at 3:00 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, closed fracture of the humerus, senile dementia with depressive features, Alzheimer's disease, depressive disorder, malnutrition, and sleep disturbance.</p> <p>Review of the quarterly 5/28/13 Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented. She did have the behavior of wandering at least 1 to 3 days. The resident needed assistance with all of her activities of daily living.</p>				

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	<p>Review of Nursing Notes dated 6/23/13 at 6:45 a.m., indicated the resident was found on the floor in room 320 lying in front of the bathroom door. The resident indicated she was going home then fell. The resident complaints of pain to her left arm. 911 was called and the resident was transported to the Emergency Room.</p> <p>Continued review of Nursing Notes dated 6/23/13 at 1:54 p.m., indicated the resident returned to the nursing home with a fracture of the left humerus upper arm. The resident was wearing a sling to that arm upon arrival.</p> <p>Review of Physician Orders dated 6/23/13 indicated an order for Norco (a narcotic pain medication) 5-325 milligrams (mg) three times a day for pain due to the fracture.</p> <p>Review of the Electronic Medication Administration Record (EMAR) indicated the Norco was scheduled to be administered at 12:00 a.m., 8:00 a.m., and 4:00 p.m. Continued review of the EMAR for the months of June and July 2013 indicated the resident received the Norco medication from 6/23-6/30 and 7/1-7/18/13 three times a day.</p>			

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	<p>Review of the 6/23/13 current care plan indicated the resident had potential for pain related fracture left upper arm. The Nursing approaches were to administer pain medication as per order, left arm sling daily, monitor signs and symptoms of pain, and notify Physician as needed.</p> <p>Continued record review indicated there was no evidence of a pain assessment for review at the time the resident was started on the Norco.</p> <p>Review of the current 2011 Pain Management Guideline policy provided by the D Wing Unit Manager indicated "Following an acute change in condition when pain is suspected, (e.g. new fracture), the licensed nurse assesses the resident for pain, using the pain scale or the PAINAD scale listed on the Pain Evaluation Tool and document assessment findings on this record...."</p> <p>Interview with the D-Wing Unit Manager on 7/18/13 at 11:42 a.m., indicated there was no pain assessment completed at the time the resident was placed on the scheduled pain medication of Norco.</p> <p>Interview with the Director of Nursing</p>			

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	(DoN) on 7/18/13 at 12:00 p.m., indicated a pain assessment was to be completed prior to the start of a new pain medication. 3.1-37(a)				

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F000329 SS=D	<p>483.25(I) 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 each resident's medication regime was free from unnecessary medications related to adequate dose and monitoring of Insulin for 1 of 10 residents reviewed for unnecessary medications. (Resident #197)</p> <p>The record for Resident #197 was reviewed on 7/17/13 at 6:58 a.m. The resident's diagnoses included, but were not limited to, dementia with</p>	F000329	The facility will ensure that each residents drug regimen is free from unnecessary drugs; 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 durgs.Resident's #197 was	08/18/2013			

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	<p>behavioral disturbances, type II diabetes mellitus, hypertension, and anemia.</p> <p>Review of the Physician Recapitulation Orders dated June 2013, indicated an order for sliding scale (insulin given per blood glucose test result) Novolog (insulin) subcutaneous (under the skin) before meals, with the following doses: < (less than) 60= Call Physician 60-169=0 units 170-275=4 units 276-350=8 units 351-425=12 units 426-500=16 units 501 or > (greater than)=Call Physician</p> <p>The Medication Administration Record (MAR) dated June 2013, indicated the resident's blood glucose test result on 6/3/13 before dinner was 281 and no insulin was given, the resident's blood glucose test result on 6/5/13 before dinner was 412 and no insulin was given, and the resident's blood glucose test result on 6/17/13 before dinner was 333 and no insulin was given.</p> <p>The MAR dated July 2013 indicated the resident's blood glucose test result on 7/8/13 before lunch was 219 and no insulin was given, the</p>		<p>affected by this deficient practice. This resident's attending physician and family were notified. The facility was unable to correct the alleged deficient practice for resident #197. All residents having a diagnosis of diabetes have the potential to be affected by this deficient practice. All diabetic residents' Medical Records were reviewed and care plans were modified to reflect the use of sliding scale insulin monitoring and resident insulin administration. All facility nurses will be re-in-serviced by 8-18-13 on the facility policy regarding the use of Sliding Scale Insulin as ordered by a physician and the proper administration of insulin as it relates to the Sliding Scale protocol. The facility DNS or designee will conduct daily (5 times per week) reviews of physician orders related to sliding scale insulin administration and review MAR's documents in order to ensure that residents are receiving the proper insulin dose for a period of 30 days using the Resident Insulin Administration Audit Tool (see item #4), then weekly audits of the sliding scale insulin orders and MAR's will be conducted for an additional 60 days. Finally, the DNS, or designee will conduct monthly audits of the sliding scale insulin physician orders and MAR's documentation for a period of 90 days to ensure that all residents</p>				

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	<p>resident's blood glucose test result on 7/12/13 before breakfast was 218 and no insulin was given, the resident's blood glucose test result on 7/12/13 before dinner was 453 and no insulin was given, the resident's blood glucose test result on 7/15/13 before dinner was 407 and no insulin was given, the resident's blood glucose test result on 7/16/13 before lunch was 314 and no insulin was given, and the resident's blood glucose test result on 7/16/13 before dinner was 344 and no insulin was given.</p> <p>Interview with Unit Manager #1 on 7/18/13 at 10:30 a.m., indicated insulin should have been given according to the sliding scale and the insulin dose should have been documented on the MAR. She indicated the insulin dose may have been documented somewhere else on the MAR but was unable to find documentation to support this.</p> <p>Review of the Physician Recapitulation orders dated July 2013, indicated an order for Lantus (insulin) 14 units subcutaneous daily at bedtime, originally dated 7/8/13.</p> <p>Review of the MAR dated July 2013, indicated on 7/10/13 the resident was given 28 units of Lantus at bedtime.</p>		<p>are receiving their insulin medication per doctor's orders. The results of these audits will be reviewed as part of the facility Daily Stand Up Meeting to ensure that resident needs are being met in a timely manner. These results will also be reviewed as part of the facilities Monthly QA&A meeting. Audit findings will be reviewed in QA&A meetings for 6 months and thereafter decreased to an as needed basis as determined by the QA&A committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented..</p>				

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	<p>Interview with Unit Manager #1 on 7/18/13 at 10:30 a.m., indicated the incorrect dose of Lantus had been given.</p> <p>3.1-48(a)(6)</p>			

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the current staffing pattern was posted on a daily basis. This had the potential to affect the 153 residents residing in the facility.</p>	F000356	The facility will post the facility name, current date, the total number and the actual hours worked by Registered Nurses, Licensed Practical and Vocational nurses, certified nurse aides and resident census. The facility will	08/18/2013			

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	<p>Findings include:</p> <p>On 7/15/13 at 8:25 a.m., the posted staffing located in the facility foyer was dated 7/12/13. At 12:30 p.m., the staffing sheet was still dated 7/12/13.</p> <p>Interview with the Interim Administrator on 7/19/13 at 1:00 p.m., indicated the staffing sheet should be posted daily with the current date.</p> <p>3.1-13(a)</p>		<p>post this nursing staffing data on a daily basis at the beginning of each shift. The data will be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors using the Staffing Data Sheet (see item #7).No residents were affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice.All Departmental Managers and receptionist staff will be re-in-serviced by 8-18-13 on the policy and procedure for the daily positing of staffing data sheets in the main atrium area of the facility.The staffing Coordinator will provide an updated copy of the Staffing Data Sheet (see item #7) to the receptionist each day, Monday through Friday who will ensure that this document is posted in the facility atrium area. The administrative weekend manager on duty each Saturday and Sunday will accurately complete the Staffing Data Sheet (see item #7) and ensure that it is posted each day in the facility atrium area.The facility ED or designee will ensure that the Staffing Data Sheet (see item #7) is posted each day Monday through Friday and the administrative weekend nurse manager will ensure that the Staffing data Sheet (see item #7) is properly posted on Saturday and Sunday. Each will record this posting on the Staffing</p>		

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			Data Sheet Audit Tool (item #8) for a period of 30 days, then weekly for an additional period of 60 days, and then monthly for an additional 90 day period. Accurate Daily posting of the Staffing Data Sheet (see item #7) will be discussed as part of the facility Daily Stand Up meeting for a period of 30 days, then bi-weekly for an additional 60 day period and then monthly for another 90 day period to ensure the accurate and daily posting of the Staffing Data Sheet (see item #7). The results of the Staffing Data Sheet Audit Tools will be discussed at the facility Monthly QA&A. Audit findings will be reviewed in the QA&A meetings for 6 months and thereafter decreased to an as needed basis as determined by the QA&A Committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented.		

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions in the main dining room related to serving food that was uncovered and facility staff's hair not restrained for 1 of 8 dining rooms observed. (The main dining room) This had the potential to affect 56 residents who ate their meals in the main dining room.</p> <p>Findings include: On 7/15/13 at 12:38 p.m., the lunch meal service was observed in the main dining room. At that time, facility staff, including staff from Activities, Administration, and Nursing, served residents their meals. Up to four plates of uncovered food were placed on an uncovered cart and were taken throughout the dining room to the residents. Further observation indicated none of the facility staff who were serving food to the residents had hair coverings or</p>	F000371	The facility will procure food from sources approved or considered satisfactory by Federal, State and local authorities, and store, prepare, distribute and serve food under sanitary conditions.No residents were harmed by this alleged deficient practice however all residents had the potential to be affected by this alleged deficient practice.Facility staff will be re-in-serviced by 8-18-13 on the proper use of hairnets and plate covers during resident meal service.The facility Dietary Manager or designee will conduct random Resident Meal Audits alternating between all three daily meals. These audits will be conducted 5 times per week for a period of 30 days, then twice per week for a period of 60 days and then once per month for a additional period of 90 day in order to ensure that all serving staff are wearing hair nets or that their hair is otherwise properly controlled and that all plated food is covered at the point of service and that it remains so until it is presented to the resident (see item #9-Meal Service Audit Tool). All significant audit results	08/18/2013			

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	<p>their hair restrained.</p> <p>On 7/16/13 at 8:15 a.m., the breakfast meal service was observed in the main dining room. At that time, facility staff served the residents their trays. Further observation indicated the breakfast trays (up to four plates of food at a time) were again being served uncovered and on an uncovered transportation cart. Continued observation indicated facility staff who were serving food to the residents had no hair coverings or restraints for their hair.</p> <p>Interview on 7/19/13 at 9:38 a.m. the Certified Dietary Manager (CDM) indicated there were usually 56 residents served in the main dining room. The general policy was all staff serving residents were required to wear a hairnet.</p> <p>Review of the current policy, Dining Services Employee Hair Guidelines, on 7/19/13 at 10:00 a.m., provided the by the CDM, indicated "All staff (whether a Dining Services employee or not) serving food in dining rooms must wear hair in a manner that does not allow hair to fall beyond the shoulders (example, hair longer than shoulder length will be pulled back and restrained)."</p>		<p>will be discussed at the facilities Daily Stand Up Meetings to ensure that proper sanitary conditions are maintained at all resident meal services. All audit results will be trended and discussed at the facilities Monthly QA&A meetings for 6 months and thereafter decreased to an as needed basis as determined by the QA&A Committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented.</p>		

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	<p>Interview with the CDM on 7/19/13, at 10:12 a.m., indicated the food was served hot, placed on the cart and was the same as if it were on a hand and taken to the resident to be served. He further indicated the food service in the main dining room had not been done any other way. The CDM indicated there was no policy for serving food in the main dining room.</p> <p>Review of the current policy, Food Service Distribution, on 7/19/13 at 10:30 a.m. provided by the CDM, indicated "Cover the entree plates for all meal service not in direct dining rooms."</p> <p>3.1-21(h)(3)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure multi dose vials of insulin and multi dose containers of eye drops</p>	F000431	The facility will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs	08/18/2013			

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	<p>were dated after opening for 2 of 4 wings. (The B & E Wings)</p> <p>Findings include:</p> <p>1. On 7/17/13 at 3:17 p.m., there were two of seven insulin multi dose vials observed in a medication cart on the E Wing. Both vials were found not labeled with open dates. Further observation indicated one of five multi dose eye medications was found not labeled with an open date and two multi dose containers of eye drops with open dates of 5/17/13 and 5/23/13.</p> <p>Interview with RN #1 at that time, indicated the vials should have been labeled upon opening and would check on a policy concerning how long eye drops were good for once opened.</p> <p>2. On 7/18/13 at 10:20 a.m., on the B Wing, there were five of seven multi dose eye medications and two of 10 multi dose insulin vials found opened with no date in a medication cart.</p> <p>Interview with RN #2 at that time, indicated multi dose vials of insulin and eye medications should be labeled with the date upon opening. She further indicated the policy for</p>		<p>in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Further, the facility will ensure that all drugs and biological are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. No residents were harmed by this alleged deficient practice. However, all residents have the potential to be affected by this alleged deficient practice. All non-dated multi-dose vials of insulin and eye drop containers were destroyed and reordered through the facility pharmacy. The facility DNS or designee will do a facility wide inspection of all multi-dose vials of insulin and containers of multi-dose eye drops to ensure that all such items that are open are properly dated using the Resident insulin and Eye drops Audit Tool (see item #10). All facility nurses will be re-in-serviced by 8-18-13 on the proper protocols for the labeling of opened multi-dose vials of insulin and eye drop containers. The DNS or designee will do a weekly (5 times per week) audit of all multi-dose insulin vials and eye drop containers for a period of 30 days, then biweekly audits of</p>				

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	<p>eye drop medication was 60 days after opening.</p> <p>Further observation on 7/18/13 at 10:30 a.m., of another medication cart on the B Wing indicated one of eight multi dose eye medications was found not labeled with an open date.</p> <p>On 7/18/13 at 12:10 p.m., an Expired Meds Audit Tool was provided by Unit Manager #1 who indicated she was still looking for an actual policy.</p> <p>On 7/19/13 at 10:00 a.m., a Pharmacy resource titled "Medications with special expiration date requirements" was provided by the Director of Nursing (DoN). This resource indicated insulin vials were good for 28 days after opening and expiration dates for eye medications varied.</p> <p>Interview with the DoN on 7/19/13, at 10:15 a.m., indicated she could not find a policy regarding multi dose eye medication labeling after opening.</p> <p>3.1-25(j)</p>		<p>these vials and containers for an additional period of 60 days and then a monthly audit of these vials and containers for an additional 90 day period. All audit results will be recorded on the Resident Insulin and Eye Drops Audit Tool (see item #10). All significant audit results will be discussed at the facility Daily Stand Up meetings to ensure that all open insulin vials and eye drop containers are labeled in a timely manner. All audit results will be trended and discussed at the facilities Monthly QA&A meetings for a period of 6 months and thereafter decreased to an as needed basis as determined by the QA&A Committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented.</p>		

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an 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 observation, record review and interview, the facility failed to</p>	F000441	Residents #89, #205, #206, #217, #270, #275, #278 and #279 were	08/18/2013			

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	<p>ensure an infection control program was maintained related to not cleaning the glucometer after use for 1 of 2 glucometers observed, not wearing gloves for 1 of 2 insulin injections observed, not washing hands after glove removal for 1 of 2 insulin injections observed and not following contact isolation procedures for 5 of 5 residents who were in contact isolation. This had the potential to affect the 14 insulin dependent diabetics residing on the "C" wing and the two insulin dependent diabetics residing on the "D" wing. (Residents #89, #205, #206, #217, #270, #275, #278, and #279)</p> <p>Findings include:</p> <p>1. On 7/19/13 at 8:26 a.m., RN #3 was observed giving Resident #275 an insulin injection. After giving the injection, the RN left the room and removed her gloves by the medication cart. The RN did not wash her hands after the glove removal nor did she use an alcohol based hand gel. The RN proceeded to prepare medications for another resident and the RN touched the pills as she placed them in the medication cup.</p> <p>Review of the Handwashing/Hand</p>		<p>affected by this alleged deficient practice. The facility was unable to correct the alleged deficient practice for these residents. All residents have the potential to be affected by this alleged deficient practice. All facility nurses will be re-in-serviced by 8-18-13 on the proper policy and procedure regarding the use of gloves during the administering of resident insulin injections and the policy and procedure for proper disinfecting and cleaning of glucometers between resident uses. All direct care staff will be re-in-serviced by 8-18-13 on the hand washing procedure to be used after removal of protective gloves from their hands. All direct care staff will also be re-in-serviced by 8-18-13 on the policy and procedures associated with resident isolation procedures including those used for contact isolation precautions. The facility DNS or designee will conduct daily (5 times per week) audits (see Isolation Audit Tool-item #11) of all resident isolation rooms for a period of 30 days in order to ensure that "See Nurse Before Entering" signs are posted on all resident isolation rooms and that all isolation carts are fully stocked. Biweekly audits of these issues will be conducted for an additional 60 day period and then monthly audits will be conducted for an additional 90 days to ensure that these components of the facility isolation protocol are</p>		

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	<p>Hygiene policy provided by the Director of Nursing on 7/19/13 at 2:00 p.m., and identified as current, indicated the following: "Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: after removing gloves or aprons. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: after removing gloves. The use of gloves does not replace hand washing/hand hygiene."</p> <p>Interview with the Director of Nursing on 7/19/13 at 1:00 p.m., indicated the RN should have washed her hands after removing the gloves.</p> <p>2. On 7/18/13 at 11:27 a.m., LPN #3 was observed administering an insulin injection to Resident #279. The LPN did not wear gloves when giving the insulin injection. Interview with the LPN at the time, indicated that she should have worn gloves.</p> <p>Interview with the Director of Nursing on 7/19/13 at 1:00 p.m., indicated the</p>		<p>followed. The facility DSN or designee will conduct a minimum of five Staff Hand Washing Audits (see item #12) and five Glucometer Sanitation Audits (see item #13) per week for a period of 30 days, then five biweekly audits for an additional period of 60 days and then five monthly audits for an additional period of 90 days. All significant audit results will be discussed as part of the facility Daily Stand Up meeting and any necessary actions will be taken to ensure that facility isolation policy is followed. All audit results will be discussed at the facility Monthly QA&A meetings for a period of 6 months and thereafter decreased to an as needed basis as determined by the QA&A Committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented.</p>	

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	<p>LPN should have worn gloves when administering the injection.</p> <p>3. On 7/17/13 at 4:16 p.m., LPN #4 was observed performing a glucometer for Resident #206. After checking the resident's blood sugar, the LPN proceeded back to the medication cart and placed the glucometer on top of the medication cart. The LPN began to prepare medications for another resident.</p> <p>Interview with the LPN at the time, indicated that she would clean the glucometer before she used it again and that she would clean the glucometer with an alcohol wipe.</p> <p>Review of the Blood Glucose Monitor Decontamination policy provided by the Director of Nursing, and identified as current, on 7/19/13 at 2:00 p.m., indicated the following: "After performing the glucose testing, the nurse, wearing gloves, will use a Clorox wipe to clean all external parts of the monitor. A second wipe will be used to disinfect the blood glucose monitor."</p> <p>Interview with the Director of Nursing on 7/19/13 at 1:00 p.m., indicated the glucometer should have been cleaned with a Clorox wipe when the</p>						

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	<p>LPN was done.</p> <p>4. On 7/17/13 at 1:50 p.m., there was no sign posted Resident #217's room door that indicated the resident was in isolation.</p> <p>On 7/18/13 at 8:45 a.m., there was no sign posted on the resident's room door to indicate the resident was in isolation. Continued observation indicated there was an isolation cart located in the room that had masks. The cart did not have gloves or gowns in it.</p> <p>The record for Resident #217, was reviewed on 7/16/13 at 1:40 p.m. A Physician's Order dated 6/3/13 indicated the resident was to be put on contact isolation due to a positive C.diff culture (Clostridium difficile, a contagious infection of the intestinal tract). The July 2013 Physician Order Statement (POS) indicated, "maintain contact isolation everyday, every shift". A care plan was initiated 6/3/13 for isolation. The goal was to maintain isolation procedures per policy. Another care plan dated 6/8/13 was for infection related to C.diff. Interventions included, but were not limited to, follow contact isolation precautions including</p>				

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	<p>signage on patient's door and isolation cart in room.</p> <p>Interview with the B Wing Unit Manager on 7/18/13 at 9:03 a.m., indicated the resident on contact isolation and should have a sign on her door directing visitors to see the nurse before entering. She further indicated the isolation cart should have gloves and gowns in it.</p> <p>5. On 7/18/13 at 9:50 a.m., Resident #205's room door had a sign which indicated visitors should see the nurse before entering the room.</p> <p>The record for Resident #205, was reviewed on 7/18/13 at 10:00 a.m. The resident was admitted to the facility on 5/17/13. Diagnoses included a bloodstream infection due to a central venous catheter. The July 2013 POS indicated resident was on contact isolation. There was no care plan in the resident's record relating to bloodstream infection or contact isolation.</p> <p>Interview with the C Wing Unit Manager and LPN #4 on 7/18/13 at 10:01 a.m., indicated they did not know why the resident was in isolation. They reviewed the resident's record and were unable to</p>				

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	<p>determine isolation type. The Unit Manager indicated he would contact medical records to find out. The Unit Manager further indicated there should be a care plan related to the isolation and infection in the resident's record.</p> <p>On 7/18/13 at 1:00 p.m., a care plan was received from the C Wing Unit Manager. The care plan was dated 5/25/13 and indicated the resident was on contact isolation for infection to the wounds. Further interview with the Unit Manager on 7/19/13 at 11:30 a.m., indicated the care plan was in a book in his office and not in the resident's record.</p> <p>6. On 7/18/13 at 9:50 a.m., Resident #89's room door had a sign that indicated visitors should see nurse before entering the room. There was an isolation cart in the room that had masks and gloves, it did not have gowns in it.</p> <p>The record for Resident #89, was reviewed on 7/18/13 at 10:05 a.m. There was no order for isolation precautions in the July or June 2013 POS. There was a microbiology result dated 7/3/13 that indicated the resident had Escherichia Coli bacteria in the urine. A Physician's Order for</p>						

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	<p>Macrobid (an antibiotic) was received on 7/3/13. There was no care plan related to an urine infection or isolation in the resident's record.</p> <p>Interview with the C Wing Unit Manager on 7/18/13 at 10:01 a.m., indicated there should be a care plan relating to the infection and isolation in the resident's record.</p> <p>On 7/18/13 at 1:00 p.m., a care plan was received from the C Wing Unit Manager. The care plan was dated 7/6/13 and indicated the resident was on contact isolation for a urinary tract infection. Further interview with the Unit Manager on 7/19/13 at 11:30 a.m., indicated the care plan was in a book in his office and not in the resident's record.</p> <p>7. On 7/18/13 at 9:55 a.m., there was a sign posted on Resident #278's room door to see nurse before entering.</p> <p>The record for Resident # 278 , was reviewed on 7/18/13 at 1:50 p.m. The resident was admitted on 7/15/13. Diagnoses included pressure ulcers to the buttocks and heels. A Patient Transfer Form dated 7/15/13 indicated the resident had VRE (Vancomycin Resistant Enterococcus,</p>						

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	<p>a drug resistant infection) to wounds and was in contact isolation. There was a care plan dated 7/15/13 for wound infections that included, "isolation as ordered". The July 2013 POS did not include an order for isolation.</p> <p>The record for Resident # 270, who resided in the same room as Resident #278, was reviewed on 7/19/13 at 11:35 a.m. The resident was admitted to the facility on 6/22/13. Diagnoses included frequent urinary tract infections. A care plan dated 7/16/13 for a urinary infection did not include an intervention for isolation precautions. The July 2013 POS did not include an order for isolation precautions.</p> <p>Interview with LPN #2 on 7/18/13 at 1:40 p.m., indicated both Residents #270 and #278 were in isolation for urine infections. The LPN made a phone call, and at 1:50 p.m., indicated Resident #278 had a wound infection.</p> <p>Review of the current and undated Contact Isolation Policy provided by the Director of Nursing on 7/18/13 at 10:37 a.m., indicated, "...g. Signs- The facility will implement a system to alert staff to the type of precaution</p>				

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	<p>resident requires". Further, the policy indicated, "...g(2) The facility will also ensure the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident".</p> <p>Interview on 7/18/13 at 12:00 p.m. with the Infection Control Nurse, indicated the process of notifying other staff and visitors of isolation procedures was to post a sign on the resident's door to see the nurse. The nurse would then advise them what type of precautions they should use. Each resident on isolation precautions should "definitely" have a care plan in their record relating to the infection and isolation. She further indicated each room should have an isolation cart that had gowns, gloves and masks in it. Staff were expected to use appropriate equipment dependant upon what type of infection the resident had. She indicated a Physician's Order initiated isolation and residents were on isolation until a Physician Order was received to discontinue it.</p> <p>3.1-18(a) 3.1-18(b)(2) 3.1-18(l)</p>			

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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred walls, doors, and furniture, stained ceiling tiles and stained light fixtures on 4 of 4 wings throughout the facility. This had the potential to affect the 155 residents residing in the facility. (The "B", "C", "D" and "E" wings)</p> <p>Findings include:</p> <p>During the Environmental tour on 7/19/13 at 10:57 a.m., with the Maintenance Supervisor, the following was observed:</p> <p>B wing</p> <p>a. The corner of the dresser in Room 109-2 was observed to be marred and splintered. The bathroom walls had gouges near the bottom and the caulk where the toilet meets the wall was black in color. The bedside table was gouged and marred. Two residents reside in this room.</p>	F000465	<p>The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. No residents were harmed by this alleged deficient practice but all residents have the potential to be affected by this alleged deficient practice. The facility Maintenance Staff have repaired all environmental deficiencies, ie., marred walls, doors and furniture, stained ceiling tiles, and stained light fixtures, etc., found during the facility licensure and certification survey of July 19, 2013. The facility Maintenance Staff will be re-in-serviced by 8-18-13 of the requirement to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The facility Executive Director, or designee will conduct weekly Environmental Audits (see Environmental Audit Tool-item #15) of the facility with the Maintenance Director for 30 days; then biweekly Environmental Audits will be conducted for an additional 60 days; and then monthly Environmental Audits will be conducted for an additional 90 days to ensure that the facilities residents, staff and the public in</p>	08/18/2013			

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	<p>b. The wall behind the head of bed one in Room 113 had holes and the wall was marred. Two residents resided in this room.</p> <p>c. There were gouges in the wall by the door in Room 128. Two residents resided in this room.</p> <p>d. The wall by the closet in Room 130 was marred. Two residents resided in this room.</p> <p>e. Four tables in the unit dining room were marred at the base and/or had scratched legs. Two chairs located in the dining room had scratched and marred chair arms and legs. Fifty-five residents resided on this unit.</p> <p>f. The grout in the ceramic floor tile in the left and right shower rooms was discolored and in need of cleaning. Fifty-five residents resided on this unit.</p> <p>g. There were two stained ceiling tiles located in the hall across from the Nurses' station.</p> <p>C wing</p> <p>a. The wall behind the head of bed two in Room 201 was marred. Two residents resided in this room.</p>		<p>general will have a safe, functional, sanitary, and comfortable facility environment. All significant audit results will be reviewed at the facility Daily Stand Up Meetings to ensure that all environmental concerns are addressed in a timely manner. All audit results will be presented and reviewed at the facility Monthly QA&A meetings for a period of 6 months and there after decreased to an as needed basis as determined by the QA&A Committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented.</p>		

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	<p>b. The air conditioner cover was loose in Room 202. One resident resided in this room.</p> <p>c. The wall behind the head of bed two in Room 205 was marred. Two residents resided in this room.</p> <p>d. In Room 207, the wall was marred next to bed one. The chair next to the bed was marred and the bathroom sink was cracked. The bathroom walls were scratched and marred. Two residents resided in this room.</p> <p>e. The wall behind the head of bed two in Room 209 was scratched and marred.</p> <p>f. The headboard for bed two in Room 222 was loose and leaning to the right. Two residents resided in this room.</p> <p>g. The left shower room had standing water underneath the sink and along the wall by the door. Fifty-one residents resided on the unit.</p> <p>h. Three chairs located in the unit dining room had scratched and marred legs and arms. Three dining room tables were marred at the base and/or had scratched and marred</p>			

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	<p>legs. Fifty-one residents resided on this unit.</p> <p>D wing</p> <p>a. The plastic light cover located in the hall across from Room 335 was discolored with a black substance. Fifteen residents resided on this unit.</p> <p>E wing</p> <p>a. The bed side stand and dresser located next to bed two in Room 309 were scratched and marred. The legs on the chair in the room were scratched and marred. The wall next to bed two was paint chipped and the bathroom door frame was paint chipped and marred. Two residents resided in this room.</p> <p>b. The privacy curtain for bed one in Room 310 was stained with black spots. The bed side stand was marred. The toilet seat was discolored and faded in areas. Two residents resided in this room.</p> <p>c. The bedside stand for bed two in Room 311 was scratched and marred. The plastic laminate on the window sill was peeling in areas. The front of the heat register was scratched and marred. Two residents</p>						

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	<p>resided in this room.</p> <p>d. The bathroom walls in Room 317 were paint chipped and marred. The door to the bathroom was paint chipped and marred. Two residents resided in this room.</p> <p>e. The cover of the heat register in Room 321 was scratched and marred and discolored with rust. The plastic laminate from the window sill was peeling in areas. The wall behind the head of bed two was paint chipped and marred. The base of the dresser was scratched and marred. Two residents resided in this room.</p> <p>f. Five chairs located in the hall outside of the unit dining room had scratched and marred arms and legs. Thirty-four residents resided on this unit.</p> <p>g. Three of three dining room tables in the unit dining room had scratched and marred legs. Thirty-four residents resided on this unit.</p> <p>Interview with the Maintenance Supervisor at the time, indicated all of the areas were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 07/19/2013
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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F000502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were obtained in a timely manner related to obtaining stool samples for 1 of 10 residents reviewed for unnecessary medications. (Resident #100)</p> <p>Findings include:</p> <p>The record for Resident #100 was reviewed on 7/16/13 at 2:50 p.m. A Physician's order dated 7/10/13, indicated the resident was to have stool samples screened for culture and sensitivity, ova and parasites, fecal leukocytes, clostridium difficile, and hemocult.</p> <p>Review of the laboratory results, indicated the stool specimen was not collected until 7/17/13, seven days later. The stool sample was positive for occult blood and fecal leukocytes.</p> <p>Review of the 7/2013 Bowel and Bladder report, indicated the resident had bowel movements on the following dates: 7/11 at 7:14 a.m., 4:11 p.m., and</p>	F000502	<p>The facility will provide or obtain laboratory services to meet the needs of its residents. The facility will be responsible for the quality and timeliness of the services. The facility was unable to correct the alleged deficient practice for resident #100 however a new lab specimen was obtained and sent to the lab for analysis. All residents have the potential to be affected by the alleged deficient practice. The facility has conducted a review of all resident records related to the timeliness of specimens being collected and processed by the laboratory vendor servicing this facility. No further alleged deficient practices have been identified at this time. All staff nurses will be re-in-serviced by 8-18-13 on the proper policy and procedure for processing lab orders. The facility Unit Managers or designee will conduct daily (5 times per week) audits of all new lab orders (see Lab Orders Audit Tool-item #16) for 30 days, then biweekly for an additional 60 days, then monthly for another 90 day period to ensure that all lab specimens are collected and processed in a timely manner. The DNS or designee will review audit results at the facility</p>	08/18/2013	

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	<p>11:28 p.m., 7/12 at 6:51 p.m., 7/14 at 9:13 p.m. and 11:29 p.m., 7/15 at 4:52 p.m. and 11:46 p.m., and 7/16/13 at 11:47 a.m., 7:53 p.m., and 11:24 p.m.</p> <p>Interview with the Unit Manager on 7/19/13 at 11:55 a.m., indicated the resident's lab should have been collected in a more timely manner.</p> <p>3.1-49(a)</p>		<p>Daily Stand Up meetings in order to ensure that all lab specimens are collected and transported to the lab for analysis in a timely manner. The DNS or designee will present audit results at the facilities Monthly QA&A meetings for a period of 6 months and thereafter decreased to an as needed basis as determined by the QA&A Committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented.</p>		