

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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F 000 Bldg. 00	<p>This survey was for the Investigation of Complaint IN00171519, Complaint IN00171709, Complaint IN172095, Complaint IN00172201 and Complaint IN00172344.</p> <p>Complaint IN00171519 - Unsubstantiated due to lack of evidence. Complaint IN00171709 - Unsubstantiated due to lack of evidence. Complaint IN00172095 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00172201 - Substantiated. Federal/State deficiencies are cited at F282 and F333 Complaint IN00172344 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: May 11 and 12, 2015</p> <p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Census bed type: SNF/NF: 95 Total: 95</p> <p>Census payor type:</p>	F 000	Preperation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully submit this document as our Plan of Correction for the alleged deficiencies as outline. We respectfully request Desk Compliance .	

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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F 282 SS=D Bldg. 00	<p>Medicare: 11 Medicaid: 65 Other: 19 Total: 95</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</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 record review and interviews, the facility failed to ensure physician orders for medications were administered as ordered following admission for 1 of 3 residents reviewed for admission orders in a sample of 5. (Resident "C")</p> <p>Finding includes:</p> <p>The record of Resident "C" was reviewed on 05/11/15 at 1:00 p.m. Resident "C" was admitted to the facility, on 04/10/15 at 3:00 p.m., from a local ACF (Acute Care Facility: hospital), with diagnoses</p>	F 282	<p>It is the intent of this facility to ensure physicians orders for medications are administered as ordered. The Executive Director and the Unit Manager for Resident "C" met with the family of Resident "C" following the allegation of "failure to ensure medications were administered in a timely manner." The Nurse named in the allegation was suspended pending investigation into the allegation, and is no longer employed at the facility. The ISDH was notified of the incident through the ISDH Gateway. Resident "C" chose not</p>	06/11/2015	

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	<p>including, but not limited to, morbid obesity, diabetes, depression, anxiety and recent cardiac arrest. The resident was discharged back to the ACF, by EMS (Emergency Medical Services), 7 hours after admission, at approximately 10:00 p.m. on 04/10/15.</p> <p>The Progress Notes indicated: "04/10/15 23:17 [11:17 p.m.] Admitted to this facility at 3:00 p.m. this date via [by way of] [Company name] ambulance. Daughter present. Alert/orientated x 3-capable of making needs known....Denies discomfort at this time...."</p> <p>"04/10/15 23:21 [11:21 p.m.] MD [Medical Doctor] paged to verify hospital orders that accompanied resident at 3:25 p.m."</p> <p>"4/10/15 23:25 [11:25 p.m.] Daughter requesting that all scheduled meds due be given to [Resident's name]. This RN explained that some medications will be arriving from pharmacy on the midnight shift that are ot [SIC] available in the EDC [Emergency Drug Kit]. Daughter crying, visibly upset and stating that she was informed that everything would be here waiting for her mother. This RN tried to re-explain that some meds would be coming from Indianapolis but that I</p>		<p>to return to the facility. Residents admitted to the facility are at risk to be affected by this alleged deficient practice. Nurses will be re-educated regarding the ordering of medications at the time of admission to include medications in the Automatic Dispensing Unit (ADU), Emergency Drug Cabinet (EDC), medications to be delivered by pharmacy at next scheduled delivery, and medications to be obtained via back up pharmacy. Nurses will notify Nurse Manager for instances in which medications have not been received within four (4) hours of the admission. Nurse managers will take measure to obtain medications.Nurse managers will complete admission audits for ninety (90) days. Results of these audits will be forwarded to Quality Assurance Performance Improvement (QAPI) and reviewed for six (6) months and/or as needed for a compliance percentage of 90% or greater.Systemic changes will be completed by June 11, 2015.</p>				

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	<p>could call the pharmacy to see if a dispense through a closer pharmacy was possible. Daughter then stated that her mother was having trouble breathing... [Resident's name] was in bed with HOB [Head of Bed] up without respiratory distress at this time. Daughter yelling, crying. This RN left room to attempt to contact pharmacy...Pharmacy states that they will get narcotics processed."</p> <p>"04/10/15 23:32 [11:32 p.m.] [Resident name] with noted increase and difficulty in respirations. Pursued-lipped breathing. O2 [Oxygen] on at 5L [Liter]/min [Minute] NC [Nasal Cannula] per MD orders. Staff repositioned [Resident name] to sit on edge of bed per her request. SPO2 [saturation of Oxygen] 85%. Nurse started breath TX [Treatment] via mask and bipap [mask for O2 administration] was set up. Bipap used after breathing tx. SPO2 increased to 92% and resident calmer. Nurse asked if resident wanted to go to hospital. Daughter wants resident to go but resident did not answer. Resident much calmer at this point. SPO2 93%."</p> <p>"04/10/15 23:36 [11:36 p.m.] ...This RN went to page MD when another nurse called out to call 911, that resident was losing ability to breath [SIC]. 911 was notified by the RN during which time a</p>			

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	<p>code blue was called by other staff with the resident. All facility responded."</p> <p>"04/10/15 23:41 [11:41 p.m.] [at] Approximately 2135 [9:30 p.m.], 911 arrived and assumed care of resident....911 left facility with [Resident name] at approximately 2200 [10:00 p.m.].</p> <p>The ACF "PHYSICIAN SUMMARY & TRANSFER ORDERS TO ECF [Extended Care Facility]" with the "Discharge Medication List" orders, included, but were not limited to, the following:</p> <p>"Scheduled /Routine Medication(s)", to be administered on 04/10/15: "sertraline [antidepressant] 100 mg (milligram) 1 tab (tablet) orally once a day for 30 days...Next Due Dose: 04/10/15 9:00 p.m.... aspirin [blood thinner] 81 mg orally 2 times a day...Next Dose Due: 04/10/15 9:00 p.m. atorvastatin [control cholesterol] 40 mg orally once a day...Next Dose Due: 04/19/15 9:00 p.m. Symbicort [asthma]160 mcg [microgram] -4.5 mcg...2 puffs inhalation 2 times a day...Next Dose Due: 04/10/15 9:00 p.m. Coreg [heart failure] 6.25 mg 1 tab oral 2 times a day...Next Due Dose: 04/10/15</p>			

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	<p>9:00 p.m. Cipro [antibiotic] 250 mg 1 tab orally every 12 hours for 1 day...Next Due Dose: 04/10/15 11:00 p.m. Colace [stool softener] 100 mg 1 cap orally 2 times a day...Next Due Dose: 04/10/15 9:00 p.m. Lasix [diuretic] 40 mg 1 tab orally 2 times a day...Next Due Dose: 04/10/15 5:00 p.m. hydralazine [high blood pressure] 50 mg 2 tabs orally 3 times a day...Next Due Dose: 04/10/15 10:00 p.m. insulin aspart (Novolog)...7 units subcutaneous with meals...Next Dose Due: 04/1/10/15 6:00 p.m. insulin detemir (Levemir Flex Pen...) 30 units subcutaneous 2 times a day...Next Dose Due: 04/1/10/15 9:00 p.m. magnesium oxide 400 mg orally 2 times a day...Next Dose Due: 0410/15 9:00 p.m...."</p> <p>"As Needed Medication(s):... Xanax [anxiety] 0.25 mg...1 tab orally every 8 hours for 7 days. Last dose taken: 04/10/15 00:38 [12:38 a.m.]... Oxycodone [pain] 5 mg oral tablet: 1.5 tabs orally every 4 hours fro 10 days. Last Dose Taken: 04/10/15 1:05 p.m.... albuterol-ipratropium [shortness of breath] DuoNeb 0.5mg-2.5 mg...every 2 hours...Next Dose Due: 04/10/15 6:00 p.m...."</p>			
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	<p>The MAR (Medication Administration Record) for Resident "C," dated 04/2015, indicated the resident did not receive any medications following arrival and prior to discharge from the facility. The breathing treatment, as noted in the Progress Notes, was not recorded on the MAR.</p> <p>The Unit Manager was interviewed on 05/12/15 at 3:00 p.m. The Unit Manager indicated RN#4, who was the nurse for Resident "C" on 04/101/15, was no longer employed at the facility. The Unit Manager indicated the facility had initiated an investigation following Resident "C" being discharged to the ECF as related to the incident. This included a review of orders and correlating with the facility's automated medication dispensing system, which contains a formulary of medications routinely ordered for residents, including scheduled and PRN (as needed) medications. During the interview, the automated dispensing system's formulary was observed for inventory on a computer screen. A review of medications as ordered for Resident "C" indicated all but 2 of the medications were noted to be routinely stocked and available in the dispensing system. The Unit Manager indicated the Cipro and the Levemir were ordered from the pharmacy</p>			

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F 333 SS=G Bldg. 00	<p>but were not delivered prior to the resident's discharge back to the ACF. The Unit Manager indicated all but 2 ordered medications for Resident "C" were available on site and should have been administered during the short time the resident was in the facility.</p> <p>This Federal tag relates to Complaint IN00172201.</p> <p>3.1-35(g)(2)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interviews, the facility failed to ensure medications were ordered and administered timely following admission for 1 of 3 residents in a sample of 5 reviewed for medication orders. The resident was admitted to the facility at 3:00 p.m. and did not receive the scheduled medications after admission. The resident was noted to be in distress, a code blue was called and the resident was sent back to the hospital by EMS (Emergency Medical Services) 7</p>	F 333	<p>It is the intent of this facility to ensure medications are ordered and administered timely following admission. Executive Director and the Unit Manager for Resident "C" met with the family of Resident "C" following the allegation of "failure to ensure medications were administered in a timely manner." The Nurse named in the allegation was suspended pending investigation into the allegation, and is no longer employed at the facility. The ISDH was notified of the incident</p>	06/11/2015

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	<p>hours after admission. (Resident "C")</p> <p>Finding includes:</p> <p>The record of Resident "C" was reviewed on 05/11/15 at 1:00 p.m. Resident "C" was admitted to the facility, on 04/10/15 at 3:00 p.m., from a local ACF (Acute Care Facility: hospital), with diagnoses including, but not limited to, morbid obesity, diabetes, depression, anxiety and recent cardiac arrest. The resident was discharged back to the ACF, by EMS (Emergency Medical Service), 7 hours after admission, at approximately 10:00 p.m. on 04/10/15.</p> <p>The Progress Notes indicated: "04/10/15 23:17 [11:17 p.m.] Admitted to this facility at 3:00 p.m. this date via [by way of] [Company name] ambulance. Daughter present. Alert/orientated x 3-capable of making needs known....Denies discomfort at this time...."</p> <p>"04/10/15 23:21 [11:21 p.m.] MD [Medical Doctor] paged to verify hospital orders that accompanied resident at 3:25 p.m."</p> <p>"4/10/15 23:25 [11:25 p.m.] Daughter requesting that all scheduled meds due be given to [Resident's name]. This RN</p>		<p>through the ISDH Gateway. Resident "C" chose not to return to the facility. Residents admitted to the facility are at risk to be affected by this alleged deficient practice. Nurses will be re-educated regarding the ordering of medications at the time of admission to include medications in the Automatic Dispensing Unit (ADU), Emergency Drug Cabinet (EDC), medications to be delivered by pharmacy at next scheduled delivery, and medications to be obtained via back up pharmacy. Nurses will notify Nurse Manager for instances in which medications have not been received within four (4) hours of the admission. Nurse managers will take measure to obtain medications. Nurse managers will complete admission audits for ninety (90) days. Results of these audits will be forwarded to Quality Assurance Performance Improvement (QAPI) and reviewed for six (6) months and/or as needed for a compliance percentage of 90% or greater. Systemic changes will be completed by June 11, 2015.</p>				

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	<p>explained that some medications will be arriving from pharmacy on the midnight shift that are ot [SIC] available in the EDK [Emergency Drug Kit] . Daughter crying, visibly upset and stating that she was informed that everything would be here waiting for her mother. This RN tried to re-explain that some meds would be coming from Indianapolis but that I could call the pharmacy to see if a dispense through a closer pharmacy was possible. Daughter then stated that her mother was having trouble breathing... [Resident's name] was in bed with HOB [Head of Bed] up without respiratory distress at this time. Daughter yelling, crying. This RN left room to attempt to contact pharmacy....Pharmacy states that they will get narcotics processed."</p> <p>"04/10/15 23:32 [11:32 p.m.] [Resident name] with noted increase and difficulty in respirations. Pursed-lipped breathing. O2 [Oxygen] on at 5L [Liter]/min [Minute] NC [Nasal Cannula] per MD orders. Staff repositioned [Resident name] to sit on edge of bed per her request. SPO2 [saturation of Oxygen] 85%. Nurse started breath TX [Treatment] via mask and bipap [mask for O2 administration] was set up. Bipap used after breathing tx. SPO2 increased to 92% and resident calmer. Nurse asked if resident wanted to go to hospital.</p>			

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	<p>Daughter wants resident to go but resident did not answer. Resident much calmer at this point. SPO2 93%."</p> <p>"04/10/15 23:36 [11:36 p.m.] ...This RN went to page MD when another nurse called out to call 911, that resident was losing ability to breath [SIC]. 911 was notified by the RN during which time a code blue was called by other staff with the resident. All facility responded."</p> <p>"04/10/15 23:41 [11:41 p.m.] [at] Approximately 2135 [9:30 p.m.], 911 arrived and assumed care of resident...911 left facility with [Resident name] at approximately 2200 [10:00 p.m.].</p> <p>The ACF "PHYSICIAN SUMMARY & TRANSFER ORDERS TO ECF [Extended Care Facility]" with the "Discharge Medication List" orders, included, but were not limited to, the following:</p> <p>"Scheduled /Routine Medication(s)," to be administered on 04/10/15: "sertraline [antidepressant] 100 mg (milligram) 1 tab (tablet) orally once a day for 30 days...Next Due Dose: 04/10/15 9:00 p.m.... aspirin [blood thinner] 81 mg orally 2 times a day...Next Dose Due: 04/10/15</p>			

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	<p>9:00 p.m. atorvastatin [control cholesterol] 40 mg orally once a day...Next Dose Due: 04/19/15 9:00 p.m. Symbicort [asthma]160 mcg [microgram] -4.5 mcg...2 puffs inhalation 2 times a day...Next Dose Due: 04/10/15 9:00 p.m. Coreg [heart failure] 6.25 mg 1 tab oral 2 times a day...Next Due Dose: 04/10/15 9:00 p.m. Cipro [antibiotic] 250 mg 1 tab orally every 12 hours for 1 day...Next Due Dose: 04/10/15 11:00 p.m. Colace [stool softener] 100 mg 1 cap orally 2 times a day...Next Due Dose: 04/10/15 9:00 p.m. Lasix [diuretic] 40 mg 1 tab orally 2 times a day...Next Due Dose: 04/10/15 5:00 p.m. hydralazine [high blood pressure] 50 mg 2 tabs orally 3 times a day...Next Due Dose: 04/10/15 10:00 p.m. insulin aspart (Novolog)...7 units subcutaneous with meals...Next Dose Due: 04/1/10/15 6:00 p.m. insulin detemir (Levemir Flex Pen...) 30 units subcutaneous 2 times a day...Next Dose Due: 04/1/10/15 9:00 p.m. magnesium oxide 400 mg orally 2 times a day...Next Dose Due: 0410/15 9:00 p.m...." "As Needed Medication(s):... Xanax [anxiety] 0.25 mg...1 tab orally</p>			

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	<p>every 8 hours for 7 days. Last dose taken: 04/10/15 00:38 [12:38 a.m.]... Oxycodone [pain] 5 mg oral tablet: 1.5 tabs orally every 4 hours for 10 days. Last Dose Taken: 04/10/15 1:05 p.m.... albuterol-ipratropium [shortness of breath] (DuoNeb 0.5mg-2.5 mg...every 2 hours...Next Dose Due: 04/10/15 6:00 p.m...."</p> <p>Review of the MAR (Medication Administration Record), dated 04/2015, indicated the resident's blood glucose was not recorded for sliding scale insulin coverage. Resident "C" did not receive 9 scheduled medications due within hours of admission and which were available in the automated medication dispensing system at the time.</p> <p>The Unit Manager was interviewed on 05/12/15 at 3:00 p.m. The Unit Manager indicated RN#4, who was the nurse for Resident "C" on 04/10/15, was no longer employed at the facility. The Unit Manager indicated the facility had initiated an investigation following Resident "C" being discharged to the ACF as related to the incident. This included a review of orders and correlating with the facility's automated medication dispensing system, which contains a formulary of medications routinely ordered for residents, including</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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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
	<p>scheduled and PRN (as needed) medications. During the interview, the automated dispensing system's formulary was observed for inventory on a computer screen. A review of medications as ordered for Resident "C" indicated all but 2 of the medications were noted to be routinely stocked and available in the dispensing system. The Unit Manager indicated the Cipro and the Levemir were ordered from the pharmacy but were not delivered prior to the resident's discharge back to the ACF. The Unit Manager indicated all but 2 ordered medications for Resident "C" were available on site and should have been administered during the short time the resident was in the facility.</p> <p>This Federal tag relates to Complaint IN00172201.</p> <p>3.1-25(b)(9)</p>			