

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 I ST LA PORTE, IN 46350
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00177023 and IN00179395.</p> <p>Complaint IN00177023- Substantiated. Federal/State deficiency related to the allegations is cited at F309.</p> <p>Complaint IN00179395- Substantiated. Federal/State deficiency related to the allegation is cited at F309.</p> <p>Survey dates: August 6 &amp; 7, 2015</p> <p>Facility number: 000023 Provider number: 155062 AIM number: 100289400</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 11 Medicaid: 44 Other: 9 Total: 64</p> <p>Sample: 8</p>	F 0000		
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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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F 0309 SS=D Bldg. 00	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 wound care treatments were completed as ordered and non pressure skin impairments were assessed and evaluated on an ongoing basis for 1 of 3 residents reviewed with non pressure areas of skin alteration in a sample of 8. (Resident #D)</p> <p>Finding includes:</p> <p>During the Orientation tour on 8/6/15 at 4:40 a.m., Resident #D was ambulating near the foot of her bed. The resident had Kerlex bandage wraps to both of her legs from her ankle areas to near the knee area. There were no tubi-grips (wraps</p>	F 0309	<p>1. Resident #D wounds were re-assessed per the Unit Manager (UM) and the Director of Nursing (DNS) on 8/6/2015 and new "Wound Evaluation Flow Sheets" were completed. Resident's physician was contacted per the DNS and provided with the current measurements and assessment of the wound on 8/7/2015. Resident's physician choose to not change the treatment that he had initiated after visualizing the wound on 7/30/2015. Physician did place resident on antibiotic therapy on 8/7/2015. 2. All current wounds were re-assessed per the UM and DNS with no other inaccuracies of documentation related to wound assessments identified. A facility</p>	09/04/2015	

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	<p>that go around dressing or extremities to provide support) on either of the resident's legs.</p> <p>On 8/6/15 at 5:40, a.m., 6:15 a.m. and 8:04 a.m., Resident #D was in bed. The resident was awake. There were no tubi-grips covering the Kerlix dressings on either of her legs. No staff were present in the room providing care for the resident at the above times.</p> <p>On 8/6/15 at 8:15 a.m., Resident D was sitting in a wheel chair in the Main Dining Room. No tubi-grips were in place to her right or left lower extremities.</p> <p>On 8/6/15 at 9:35 a.m., Resident D was in bed. No tubi-grips were in place to her right and left lower extremities. No staff were present in the room providing care to the resident.</p> <p>On 8/6/15 at 11:55 a.m., Resident #D was sitting in a wheel chair in her room. Nursing Unit Manager #1 entered the resident's room to provide wound care. The Unit Manager indicated staff had just completed cleaning the lower extremities as ordered and rinsing the areas while the resident was in the shower room. There was an open area on the resident's right calf area. The area extended from the</p>		<p>wide audit was also completed immediately per the DNS, UM, and Assistant Director of Nursing (ADNS) to determine if all residents who had an order for Tubigrip stockings had them in place with deficiencies corrected as identified. 3. LPN #1 re-inserviced per the DNS on 8/7/2015 related to timely documentation of wound assessments on the "Wound evaluation flow record." Licensed Nursing Staff to be re-inserviced related to assessment of wounds, skin assessment procedures, skin assessment documentation, completion of the Wound Evaluation Flow sheet and on-going monitoring of identified areas and dressing changes. (See attachments "Wound Care," "Wound Evaluation Flow Sheet," and "Skin Assessment Guidelines," and "Clean Dressing Change Competency." Nursing staff also to be re-inserviced on ensuring Tubigrips are applied if ordered. The DNS or designee and the Unit manager will complete weekly wound rounds with the Unit Manager to assess all wounds. All wounds assessments will be documented per the Unit manager and reviewed per the DNS or designee with re-inservicing to be completed if deficiencies are identified. ADNS or designee to complete weekly rounds to ensure all residents who have</p>				

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	front of the calf around to the posterior (back) side of the calf. The area irregular in shape and covered more then 1/2 of the front of the calf and 1/4 of the posterior calf. The wound bed was pale yellow in color. There were four area attached to the edges of the above areas on the anterior(front) aspect of the calf. The Unit Manager applied Lotrimin (a topical medication to treat fungal infections) ointment to the four areas. The Unit Manage applied a Silver Alginate dressing (a dressing with antimicrobial actions and to absorb exudate from wounds) to the open area. The dressing covered the anterior aspect of the open area. The dressing did not cover the entire part of the wound on the posterior aspect of the calf. The Unit Manager then wrapped the area with Kerlix. The Unit Manager did not apply tubi-grips over the Kerlix. The resident also had an open area to the left calf area. The area was irregular in shape and the size of a 1/2 dollar piece. The center of the pale yellow in color. There were also three open red areas around the above area. These areas were round and the size of quarters. The center of each of the areas was pale red in color. There was dry flaky scabbed intact skin noted to the resident's right heel. No open area were noted.		Tubigrip ordered have it in place per order, DNS to complete weekly. 4. DNS to present findings to the Quality Assessment Process Improvement (QAPI) committee monthly. The QAPI committee to review for any trends or patterns (3 deficient practices per month will be considered a trend/pattern).				

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	<p>The record for Resident #D was reviewed on 8/6/15 at 8:01 a.m. The resident's diagnoses included, but were not limited to cellulitis, diabetes mellitus, gout, anemia and high blood pressure. The resident was sent to the hospital on 5/27/15 and returned to the facility on 6/2/15.</p> <p>Review of the 4/22/15 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required limited assistance with personal hygiene, dressing and ambulating in her room. The assessment indicated the resident had no skin integrity concerns noted.</p> <p>Hospital records indicated the resident was admitted to the hospital on 5/27/15. The 5/28/15 Clinical Progress Note indicated the resident was assessed for bilateral lower extremity cellulitis. A 14 cm (centimeter) x 18 cm of red oozing skin was noted to the right lower extremity at ankle level. A dark area of oozing from the skin was noted at the lateral aspect of the left lower extremity. This area measured 7.5 x 8.2 cm. Erythema and edema were noted to both</p>			

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	<p>lower extremities. A fluid filled blister was noted on the anterior medical aspect of the right lower extremity several inches below the knee. A 0.5 cm x 0.6 cm x 0.2 cm open wound was present on the left lateral heel.</p> <p>The 6/1/15 Clinical Progress Note indicated the resident had a 10 cm x 12 cm x .2 cm open area on the right outer aspect of the lower leg with approximately 50% clean red wound bed and 50% slough (necrotic or avascular tissue in the process of separating from viable tissue) tissue in the wound bed.</p> <p>The 6/2/15 Admission/Readmission assessment was reviewed. No open area were recorded on the assessment . On 8/7/15 at 10:50 a.m., LPN #1 provided written documentation of wound assessments she had completed on 6/2/15 when the resident returned from the hospital. The LPN indicated she had assessed the resident's lower extremities, wrote the assessments and measurement on a notebook and failed to record the above in the resident's record until this time. The LPN's records indicated the following skin alterations were noted.</p> <p>-Right outer ankle: 10.6 x 9.2 x 0.2 cm with 50 % yellow slough</p> <p>-Right upper calf: 3.0 x 2.6 x 0.1 with pink wound bed</p>				

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	<p>-Left posterior lower leg: 5.6 x 6.2 with 50% yellow slough</p> <p>-Left upper inner calf 3.6 x 3.9 with superficial pink wound bed.</p> <p>The 6/2/15 Physician orders were reviewed. There was an order written to cleanse the open areas to the both lower extremities with normal saline, apply Vaseline gauze and cover with an ABD (large bandage) and wrap with rolled gauze daily and as needed for soilage or dislodgement.</p> <p>Wound Evaluation Flow Sheets were reviewed. Columns on the Flow Sheets that were to be completed included, the amount, color, consistency of exudate (with "none" to be checked in not not present). The type of wound bed tissue was to be completed with choices to mark which included epithelial, granulation, slough, or necrotic. A comments section was also noted for additional information to be documented.</p> <p>A Flow Sheet for the "Left upper Calf open area," dated 6/4/15, noted the following entries:</p> <p>*6/4/15: 0.5 cm x 0.5 cm no depth. The Exudate and Wound bed columns were not completed.</p> <p>*6/10/15: 2.5 cm x 1.2 cm , no depth marked. The Exudate and Wound bed</p>			

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	<p>columns were not completed.</p> <p>*6/17/15: 2.7 cm x 1.6 cm x 0.1 cm. Heavy amount of pink exudate noted. The Wound Bed column was not completed.</p> <p>No further entries were completed on this Flow Sheet</p> <p>A Flow Sheet for the "Left Calf," dated 6/22/15, noted the following entries:</p> <p>*6/22/15: 4.0 cm x 6.0 cm x 0.3 cm with serous drainage present and granulation tissue to the wound bed.</p> <p>*6/29/15: 4.0 cm x 6.0 cm x &lt;0.3 cm with serous drainage preset and granulation to the wound bed.</p> <p>*7/6/15: 4.0 cm x 5.9 cm with serous drainage preset and granulation to the wound bed.</p> <p>*7/20/15: 5 cm x 5 cm x &lt;0.2 cm with serosanguinous drainage- No description of the wound bed was completed.</p> <p>*7/30/15: 5.1 cm x 5.2 cm x &lt;0.2 cm with clear thin drainage- No description of the wound bed was completed.</p> <p>No assessments were noted between 7/6/15 and 7/19/15. No assessment were noted between 7/21/15 and 7/30/15.</p> <p>A Flow Sheet for the "Left upper Calf open area," dated 6/4/15, noted the following entries:</p> <p>*6/4/15: 0.5 cm x 0.5 cm no depth. The Exudate and Wound bed columns were</p>			

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	<p>not completed.</p> <p>*6/10/15: 2.5 cm x 1.2 cm , no depth marked. The Exudate and Wound bed columns were not completed.</p> <p>*6/17/15: 2.7 cm x 1.6 cm x 0.1 cm. Heavy amount of pink exudate noted. The Wound Bed column was not completed.</p> <p>No further entries were completed on this Flow Sheet.</p> <p>A Flow Sheet for the "Right Calf" noted the following entries:</p> <p>*6/22/15: 10.0 cm x 9.5 cm x &lt;0.3 cm . Heavy amount of serous drainage. 99% granulation and 1% scattered yellow to the Wound bed.</p> <p>Current treatment: Silver Alginate.</p> <p>*6/29/15: 10.0 cm x 9.5 cm x &lt; 0.3 cm. Heavy amount of serous drainage. 100% granulation to the Wound Bed.</p> <p>Current treatment: Silver Alginate.</p> <p>*7/6/15: 10.0 cm x 9.0 cm x &lt; 0.3 cm. Heavy amount of serous drainage. 100% granulation to the Wound Bed.</p> <p>Current treatment: Silver Alginate.</p> <p>*7/20/15: 14 cm x 9.5 cm x &lt;0.2 cm. Heavy amount of serous exudate. No assessment of the Wound Bed was documented</p> <p>Current treatment: Silver Alginate</p> <p>*7/30/15: 5.1 cm x 5.2 x &lt; 0.2 cm. Heavy amount of serous exudate. No assessment of the Wound Bed was</p>			

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	<p>documented</p> <p>Current treatment: Lotrimin 2 % cream.</p> <p>No Wound assessments of the right calf were documented between 7/7/15 - 7/19/15.</p> <p>New Wound Evaluations Flow Sheet forms were initiated on 8/6/15. The Director of Nursing indicated the areas were all assessed by herself and the Unit Manager.</p> <p>Five separate Flow Sheets were initiated, on 8/6/15, for areas to the Left calf. The Wound beds of (4) of the (5) left calf areas noted 100% slough of the wound bed tissue.</p> <p>Nine separate flow sheet were initiated, on 8/6/15, for areas to the right calf. The Wound beds of (4) of the (9) right calf areas noted 100% slough of the wound bed tissue. The largest area was 10.2 cm x 12 cm x &lt;0.2 cm.</p> <p>The current Physician orders were reviewed. An order was written on 6/26/15, to cleanse the open area on the right calf with normal saline, apply silver alginate and cover with a foam, apply rolled gauze and secure with tape twice a day and as needed.</p>			

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	<p>A Physician order written on 7/30/15, indicated Lotrimin cream was to be applied to the bilateral lower extremities after washing the legs with Ketoconazole (an anti-fungal) shampoo and soaking the legs in warm water for 15 minutes, apply Lotrimin cream, cover the area with a dry dressing, wrap with Kerlix, and apply tubi-grips every day.</p> <p>A Care Plan initiated on 4/15/15 indicated the resident had stasis ulcers present to the bilateral lower extremities. The Care Plan was last revised on 7/30/15. Care Plan interventions included to provide treatments as ordered and monitor for the wounds for healing progress progress or lack of healing.</p> <p>When interviewed on 8/6/15 at 10:00 a.m., the Director of Nursing indicated a complete assessment of the wounds should have been completed on the Admission assessment when the resident returned from the hospital on 6/2/15. The Director of Nursing indicated the admitting Nurses' assessment was not written on a facility documented and was not in the resident's record up until this time. The Director of Nursing indicated the tubi grips should have been in place as ordered by the Physician.</p> <p>When interviewed on 8/7/15 at 8:05 a.m.,</p>			

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	<p>the Director of Nursing indicated wound assessments were completed by herself and the Unit Manager yesterday and slough noted in several wounds. The Director of Nursing indicated all the wounds were to be assessed weekly and the required documentation on the flow sheets should have been completed. The Director of Nursing indicated increased slough was observed to the leg wounds during her assessment of the resident's legs and this was not reflected on the Wound Flow Sheets prior to 8/6/15. The Director of Nursing indicated changes in the wounds should have been assessed to determine if treatments were effective or changes were needed.</p> <p>The facility policy titled "Skin Integrity Guideline" was reviewed on 8/7/15 at 11:20 a.m. There was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated a skin Evaluation/ Observation was to be completed within the first 24 hours of admission and the status of wounds was to be monitored weekly. The policy also indicated Weekly Skin Evaluation/Observations were to be completed weekly by a licensed Nurse on the Weekly Skin Review. Licensed Nurses were also to document weekly on identified wounds using the Wound</p>			

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	<p>Evaluation Flow Sheets.</p> <p>This Federal tag relates to Complaints IN00177023 and IN00179395.</p> <p>3.1-37(a)</p>				