

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155136	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/30/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVE LA PORTE, IN 46350
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F0000	<p>This visit was for the Investigation of Complaint IN00102899.</p> <p>This visit was done in conjunction with the Recertification and State Licensure Survey. This visit also included the investigation of Complaint IN00102157.</p> <p>Complaint IN00102899- Substantiated with Federal/State deficiencies related to the allegations cited at F282 and F328.</p> <p>Survey Dates: January 23, 24, 25, 26, 27, and 30, 2012</p> <p>Facility Number: 000061 Provider Number: 155136 AIM Number: 100288620</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. Janet Adams, R.N. Kathleen Vargas, R.N.</p> <p>Census Bed Type: 150 SNF/NF 150 Total</p> <p>Census Payor Type: 26 Medicare</p>	F0000		
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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>111 Medicaid 13 other 150 Total</p> <p>Stage 2 Sample: 33</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 2, 2012 by Bev Faulkner, RN</p>			
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F0282 SS=E	<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 physician's orders were followed as written related to laboratory tests and blood glucose monitoring for 2 of 10 residents reviewed for unnecessary medications. The facility also failed to ensure the plan of care was followed as written related to the use of oxygen for 1 of 3 residents reviewed for respiratory services of the 3 who met the criteria for respiratory services and for 1 of 3 residents reviewed for non-pressure related skin conditions of the 3 who met the criteria for non-pressure related skin conditions. (Residents #C, #E, #H, and #I)</p> <p>Findings include:</p> <p>1. On 1/24/12 at 1:44 p.m., Resident #C was observed in her room in bed sleeping. The resident was observed to have oxygen tubing in her nares. The oxygen tubing stretched to the resident's portable oxygen tank that was strapped to the back of her wheelchair. The arrow on the portable tank was in the "red zone"</p>	F0282	<p>F 282Step I:1. Resident #C was connected to the oxygen concentrator positioned next to the bed. The Memory Lane Unit Manager ensured that the concentrator was turned on and set to the appropriate liter flow for the resident. The resident was assessed and found to be in no respiratory distress.2. The physician order was corrected for the Blood Glucose Level to be obtained every two days at alternating time for Resident #E.3. The Laboratory was notified to resume the routine laboratory testing for Resident #H. The BMP, CBC, and HgbA1C results were obtained and were within normal limits.4. The bruise on the left hand of Resident #I was assessed, measured, and documented.Step II:1. The DNS conducted visual observations of all residents receiving oxygen therapy to ensure that all oxygen devices were turned on and set to the appropriate liter flow. No deficiencies were noted2. All residents with physician orders for Blood Glucose Levels were reviewed to ensure accurate frequency of testing. No deficiencies were noted.3. All residents with routine physician orders for laboratory testing were audited to ensure that all results were obtained as ordered. Any</p>	02/29/2012			

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	<p>indicating that it was empty and the dial on the tank was set at "0." At 2:50 p.m., the resident remained in her room in bed. The resident remained connected to the portable oxygen tank. The dial on the portable oxygen tank was set at "0."</p> <p>Interview with CNA #1 at 2:54 p.m., indicated the resident's portable oxygen tank was not turned on, she further indicated the tank needed to be filled. Interview with the Memory Lane Unit Manager at the time indicated the resident should have been connected to the oxygen concentrator next to her bed rather than the portable oxygen tank. She further indicated the portable oxygen tank was not turned on.</p> <p>The record for Resident #C was reviewed on 1/25/12 at 10:42 a.m.</p> <p>Physician's Orders, dated 11/17/11, indicated the resident was to wear oxygen at 4 liters continuously by way of nasal cannula.</p> <p>The plan of care, dated 11/18/11, indicated the resident had an alteration in respiratory status due to chronic obstructive pulmonary disease due to congestive heart failure. The interventions listed,</p>		<p>deficiencies noted were corrected.4. A head to toe skin assessment was completed on all residents in the facility to ensure that all skin issues were assessed, measured, and documented. Any deficiencies noted were corrected.Step III:1.All Nursing Staff were re-instructed regarding Oxygen Administration Procedures. The DNS and/or designee will conduct oxygen therapy observations on 3 residents daily for seven months and will report findings to the QA&A Committee monthly.2. All Licensed Nursing Staff were re-instructed regarding the procedure for obtaining Blood Glucose Levels as per physician order. The DNS and/or designee will audit 5 residents with physician orders for Blood Glucose Levels weekly to ensure results were obtained as ordered and report findings to the QA&A Committee monthly for seven months.3. All Licensed Nursing Staff were re-instructed on the Lab Processing/Tracking Guideline. The DNS and/or designee will audit 10 laboratory tests weekly to ensure that results were obtained as ordered and report findings to the QA&A Committee monthly for seven months. 4. All Nursing Staff were re-instructed regarding the Skin Integrity Guideline. The DNS and/or designee will conduct 5 random skin assessments weekly for seven months to</p>		

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	<p>indicated the oxygen was to be administered per physician order and oxygen at 4 liters by the way of a nasal cannula.</p> <p>2. The record for Resident #E was reviewed on 1/26/12 at 1:43 p.m. Resident's # E's diagnoses included, but was not limited to, diabetes.</p> <p>A Physician's Order, dated 12/9/11, indicated the resident's blood glucose was to be monitored once daily every 2 days and the time was to be alternated between 6:00 a.m. and 4:00 p.m.</p> <p>The January 2012 Medication Administration Record (MAR) indicated the resident's blood sugar was being checked twice a day every other day rather than once every other day at alternating times.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 1/27/12 at 12:40 p.m., indicated a clerical error was made when the January 2012 MAR was printed and the resident was receiving her blood sugars twice every other day rather than once every other day at alternating times.</p> <p>3. The record for Resident #H was reviewed on 1/25/12 at 8:56 a.m. The</p>		<p>ensure that all skin issues are identified and will report findings to the QA&A Committee monthly. Step IV: The QA&A Committee will monitor for any trend monthly for seven months and will determine the need for any further and/or ongoing monitoring.</p>		

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	<p>resident had diagnoses that included, but were not limited to, congestive heart failure, diabetes and paraplegia.</p> <p>The January 2012 Physician Order Sheet indicated a physician order for a BMP (Basic Metabolic Profile, a laboratory test) to be obtained every 3 months. The order for the laboratory test was obtained on 6/28/11. Review of the laboratory test results indicated a BMP was obtained on 6/30/11 in the facility and on 12/20/11 in the Emergency Department of the local hospital. There were no BMP results for September 2011.</p> <p>The January 2012 Physician Order Sheet indicated a physician order for a CBC (Complete Blood Count) to be obtained every 3 months. The order for the laboratory test was obtained on 6/28/11. Review of the laboratory test results indicated a CBC was obtained on 6/30/11 in the facility and on 12/20/11 in the Emergency Department of the local hospital. There were no CBC results for September 2011.</p> <p>The January 2012 Physician Order Sheet indicated a physician order for a HgbA1c (Glycohemoglobin level, a laboratory test to assess glucose levels) to be obtained every 3</p>			

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	<p>months. The order for the laboratory test was obtained on 6/28/11. Review of the laboratory test results indicated there was a HgbA1c dated 6/30/11, there were no other results for a HgbA1c.</p> <p>Interview with the Rainbow Lane Unit Manager on 1/25/12 at 2:42 p.m., indicated the resident had been discharged to the hospital in June 2011. She indicated that at the time of the discharge, the laboratory discontinued the resident's lab orders for the BMP, CBC and HgbA1c to be obtained every 3 months. The last lab obtained in the facility was in June 2011. She indicated the staff did not complete a laboratory requisition form to notify the lab of the physician's order for the laboratory tests when the resident was readmitted to the facility. She indicated the BMP, the CBC and the HgbA1c were not obtained as ordered by the physician.</p> <p>4. Resident # I was observed on 1/23/12 at 3:40 p.m., there was a nickel sized area of bruising to the top of the resident's left hand.</p> <p>The resident was again observed on 1/24/12 at 3:26 p.m. The bruise on her left hand was noted. Interview with the resident at that time indicated</p>						

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	<p>she bumped her hand on something, states it happens often.</p> <p>The record for Resident # I was reviewed on 1/26/12 at 8:15 a.m. The resident had diagnoses that included, but were not limited to, anemia, diabetes and anxiety disorder.</p> <p>The January 2012 Physician Order Sheet indicated the resident had physician's orders for aspirin (an anticoagulant medication) 81 mg (milligrams) daily.</p> <p>There was a care plan, dated 6/29/11, that indicated: At risk for complications related anticoagulant or antiplatelet medication due to : post orthopedic surgery, receives ASA (aspirin) daily The goal: will remain without complications from bleeding or injury The interventions: -apply prolonged pressure to venipuncture sites -monitor medication regime for medications which increase effects -observe for adverse reaction: fever, skin lesions, anorexia -observe for s/s (signs and symptoms) of bleeding i.e. tarry stools, blood in urine, bruising, petechiae (small hemorrhagic spots in the skin)</p>			
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	<p>Review of the progress notes, dated 1/18/12 through 1/26/12, indicated there was no evidence that the bruise had been observed.</p> <p>Review of the "Resident Shower Sheet/Skin Concern Documentation" forms, dated 1/21/12 and 1/25/12, for Resident # I, indicated there was no evidence the resident's bruise was observed.</p> <p>On 1/26/12 at 11:22 a.m., the resident was again observed. The bruise on the back of the resident's left hand was dark purple in color . Interview with the Rainbow Lane Unit Manager at that time, indicated the bruise was present on the resident's left hand.</p> <p>Interview with the Rainbow Unit Manager on 1/26/12 at 11:24 a.m., indicated the resident had a bruise on her left hand. She indicated the progress notes and the "Resident Shower Sheet/Skin Documentation" forms did not identify the bruise.</p> <p>Interview with the Director of Nursing on 1/30/12 at 7:53 a.m., indicated that when staff first identify a bruise they were to assess the area, measure the area and document the findings in the</p>			
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	<p>progress notes. She indicated the resident's care plan to observe for signs and symptoms of bleeding was not followed.</p> <p>This Federal tag relates to Complaint IN00102899.</p> <p>3.1-35(g)(2)</p>			
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F0328 SS=D	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review and interview, the facility failed to ensure oxygen was in use as ordered and set at the correct flow rate for 2 of 3 residents of the 3 who met the criteria for respiratory services. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. On 1/24/12 at 1:44 p.m., Resident #C was observed in her room in bed sleeping. The resident was observed to have oxygen tubing in her nares. The oxygen tubing stretched to the resident's portable oxygen tank that was strapped to the back of her wheelchair. The arrow on the portable tank was in the "red zone" indicating that it was empty and the dial on the tank was set at "0." At 2:50 p.m., the resident remained in her room in bed. The resident remained connected to the portable oxygen tank. The dial on the portable oxygen tank was set at "0."</p>	F0328	F 328Step I: 1. Resident #C was connected to the oxygen concentrator positioned next to the bed. The Memory Lane Unit Manager ensured that the concentrator was turned on and set to the appropriate liter flow for the resident. The resident was assessed and found to be in no respiratory distress.2. The portable oxygen tank was turned on to the appropriate liter flow for Resident #B. The resident was assessed and found to be in no respiratory distress.Step II: To include all residents cited.The DNS conducted visual observations of all residents receiving oxygen therapy to ensure that all oxygen devices were turned on and set to the appropriate liter flow. No deficiencies were noted.Step III: All Nursing Staff were re-instructed regarding Oxygen Administration Procedures. The DNS and/or designee will conduct oxygen therapy observations on 3 residents daily for seven months and will report findings to the QA&A Committee monthly.Step	02/29/2012			

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	<p>Interview on 1/24/12 with CNA #1 at 2:54 p.m., indicated the resident's portable oxygen tank was not turned on, she further indicated the tank needed to be filled. Interview with the Memory Lane Unit Manager at the time indicated the resident should have been connected to the oxygen concentrator next to her bed rather than the portable oxygen tank. She further indicated the portable oxygen tank was not turned on.</p> <p>The record for Resident #C was reviewed on 1/25/12 at 10:42 a.m. The resident's diagnoses included, but were not limited to, pneumonia and chronic pulmonary heart disease.</p> <p>Physician's Orders, dated 11/17/11, indicated the resident was to wear oxygen at 4 liters continuously by the way of a nasal cannula.</p> <p>The resident's Admission Minimum Data Set Assessment (MDS), dated 11/24/11, indicated the resident had a diagnoses of chronic pulmonary heart disease and that she received oxygen therapy.</p> <p>The plan of care, dated 11/18/11, indicated the resident had an alteration in respiratory status due to</p>		IV: The QA&A Committee will monitor for any trends monthly for seven months and will determine the need for any further and/or ongoing monitoring				

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	<p>chronic obstructive pulmonary disease due to congestive heart failure.</p> <p>The following interventions were listed:</p> <ul style="list-style-type: none"> -Administer oxygen as needed per physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. -Observe for shortness of breath upon exertion -Oxygen at 4 liters per nasal cannula <p>2. The record for Resident #B was reviewed on 1/25/12 at 7:45 a.m. The resident's diagnoses included, but were not limited to, obstructive bronchitis with exacerbation and chronic airway obstruction.</p> <p>A Physician's order, dated 9/13/11, indicated the resident was to wear oxygen by the way of a nasal cannula at 3 liters.</p> <p>The Quarterly Minimum Data Set Assessment, dated 12/9/11, indicated the resident was receiving oxygen therapy.</p> <p>Documentation in the nursing progress notes on 1/22/12 at 5:30</p>			
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	<p>p.m., indicated the resident's responsible party approached nursing staff in the hallway stating the resident's portable oxygen tank was turned off. The nurse assessed the resident at the time. The resident showed no signs and symptoms of distress. The oxygen tank was filled and turned on to 3 liters.</p> <p>Review of the facility investigation, dated 1/23/12, indicated the resident's daughter reported to staff that her mother's portable oxygen tank was off. The nurse immediately turned the tank on and assessed the resident.</p> <p>Interview with the Director of Nursing (DON) on 1/30/12 at 11:52 a.m., indicated based on documentation in the nursing progress notes, it appeared the resident's oxygen was off at the time of the resident's daughter's visit. She indicated the resident was assessed at the time and was found to be in no distress.</p> <p>This federal tag relates to Complaint IN00102899.</p> <p>3.1-47(a)(6)</p>						