

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/29/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint # IN00172195.</p> <p>Complaint #IN00172195 - Substantiated. Federal deficiency related to the allegations are cited at F278.</p> <p>Survey dates: May 28 and 29, 2015</p> <p>Facility number: 000039 Provider number: 155685 AIM number: 100275130</p> <p>Census bed type: SNF/NF: 150 Total: 150</p> <p>Census payor type: Medicare: 11 Medicaid: 110 Other: 29 Total: 150</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Please accept this plan of correction as our facility's response to alleged deficiencies that were identified during a survey completed on May 29th. Also, we would like to request your consideration of a desk review for compliance based upon the scope of severity was isolated and caused no actual harm.	
F 0278 SS=D	483.20(g) - (j) ASSESSMENT			

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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Bldg. 00	<p><b>ACCURACY/COORDINATION/CERTIFIED</b> The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the accuracy of skin assessments for two Minimum Data Sets (MDS) assessments for 1 of 3 residents reviewed. (Resident B).</p> <p>Finding includes:</p>	F 0278	<p><b>F 278 It is the policy of this facility to provide accuracy of skin assessments on MDS assessments for all residents. <u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b> The 5 day and 14 day MDS assessments for resident B were corrected to address pressure ulcer concerns. The MDS staff have been in-serviced on</p>	06/17/2015

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	<p>The clinical record for Resident B was reviewed on 5-28-15 at 9:30 A.M. Resident B was admitted on 2-21-15. The diagnoses included, but were not limited to, congestive heart failure unspecified, atrial fibrillation, encephalopathy, aortic valve disorders, unspecified peripheral vascular disease and shortness of breath.</p> <p>An Admission Assessment, dated 2-21-15 at 15:15 P.M., indicated, "...Skin concern # 1 [an area designated on the assessment as to the location of the skin concern]...Date first observed: 2-21-15...Site: Coccyx...Stage: II [partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough]...Size (LWD) [length, width, depth] 9 x 5 cm [centimeter]...Description: redness partial thickness loss mod [moderate] epidermis, abrasion...."</p> <p>A Wound Evaluation Flow Sheet, dated 2-24-15, indicated, "...Date: 2-24-15... Stage/Type: II...Measurements (cm) L 0.5 x W 0.5...Tissue Type Percent/Location: 100% Pink...Periwound: Wound</p>		<p>pressure area documentation requirements per CMS guidelines. <b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b> A 100 % skin audit was completed . Current MDS's of any resident with identified skin issues have been reviewed to ensure accuracy of documentation. <b><u>Measures put into place to ensure alleged deficient practice does not recur:</u></b> New skin sheets will be completed for all residents during their assessment period by the nurses. The MDS Coordinator/Designee will compare the skin sheets with the medical record and will conduct interviews with direct care staff throughout the completion of the MDS to ensure that all skin issues are appropriately documented. The nurses will receive inservice training regarding appropriate documentation requirements in accordance with pressure ulcers. <b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b> The DON/Designee will review 2 MDS's/wk of residents who have just completed a assessment period, for 4 weeks, then 1 time a month for 3 months to ensure that documentation is accurate to the resident's current condition. Results of the audits will be reviewed 1 time/month for 3 months in QAPI meeting. Any</p>				

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	<p>Margins: Intact... Surrounding Tissue: Pink... Comments: Previous superficial area to coccyx from excoriation now open...."</p> <p>There was no documentation on the Minimum Data Set assessment, Medicare 5 day, with the Assessment Reference Date of 3-2-15, to indicate the resident had pressure ulcer concerns.</p> <p>A Wound Evaluation Flow Sheet, dated 3-6-15, indicated, "...Date: 3-6-15...Stage/Type: not documented...Measurements (cm) L 0.5 x 0.7...Tissue Type Percent/Location:100% Pink...Periwound: Wound Margins: Intact...Surrounding tissue: Pink...."</p> <p>There was no documentation on the Minimum Data Set assessment, Medicare 14 day, with the Assessment Reference Date of 3-8-15, to indicate the resident had pressure ulcer concerns.</p> <p>On 5-29-15 at 2:00 P.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated Resident B did have a pressure ulcer and</p>		<p>concerns/issues identified will be addressed through the education process by the Staff Education Director. 100% trend compliance for 3 months will determine if monitoring will need to continue or be stopped to ensure alleged deficient practice will not recur. _</p>	

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	<p>that it was present and documented on the transfer sheet when Resident B was transferred to the hospital on 3-11-15...."</p> <p>On 5-29-15 at 3:20 P.M., an interview with the MDS Coordinator was conducted. The MDS Coordinator indicated she did not code Resident B as having a pressure ulcer, on the 3-2-15 or the 3-8-15, Minimum Data Set assessments. She indicated she could not find the wound sheets at the time and was told by a nurse that the pressure ulcer was healed. She further indicated she did not go to Resident B and conduct a skin assessment during the 7 day look back period.</p> <p>On 5-29-15 at 4:00 P.M., a procedure from the RAI [Reference Assessment Instrument] Manual dated May 2013, indicated but was not limited to, "...Pressure Ulcers...Steps for Assessment...1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.)..."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	This Federal tag relates to Complaint IN00172195.  3.1-31(c)(2)				