

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 03/27/2014
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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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F000000	<p>This visit was for the Investigation of Complaints IN00144570.</p> <p>This visit was in conjunction with the PSR (Post Survey Revisit) to the Investigation of Complaints IN00140057 and IN00142463 completed on January 30, 2014.</p> <p>Complaint IN00144570-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: March 26 & 27, 2014</p> <p>Facility number: 000061 Provider number: 155136 AIM number: 100288620</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF/NF: 135 Total: 135</p> <p>Censu payor type: Medicare: 12 Medicaid: 118 Other: 5</p>	F000000	<p>This Plan of Correction shall serve as this facility's credible allegation of compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in this survey. Beth Ingram Executive Director</p>	
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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>Total: 135</p> <p>Sample: 13</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 29, 2014, by Janelyn Kulik, RN.</p>			
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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview the facility failed to ensure fall preventions devices were in place and prevention interventions were followed related to floor mats not in place, bed not in the low position, and resident not in the correct wheelchair for 2 of 3 residents reviewed for falls in the sample of 13. (Residents #B and #F)</p> <p>Findings include:</p> <p>1. On 3/26/14 at 7:47 p.m., Resident #B was observed asleep in bed. There were three non-skid strips on the floor next to the resident's bed.</p> <p>The record for Resident #B was reviewed on 3/26/14 at 7:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer Disease, high blood pressure, osteoporosis, depressive disorder, and anorexia.</p> <p>The 1/14/14 Minimum Data Set</p>	F000323	<p>Step One:1. Resident B was discharged from the Living Center on 3/27/2014.2. The bed for Resident F was placed in the lowest position with a floor mat in place and CNA was instructed on the resident's plan of care. Step Two:1. All residents who utilize a wheelchair were visually inspected to ensure proper placement of the wheelchair and current falls devices.2. All residents who have a current low bed with floor mat interventions were visually inspected to ensure proper placement of the low bed with floor mat. All CNA Staff were interviewed to ensure proper use of CNA Assignment Sheets. No deficiencies were noted. Step Three:1. New name tags were applied to all wheelchairs to ensure proper identification. All Nursing Staff were re-instructed regarding placement of falls interventions including placement of proper wheelchairs. The DNS and/or designee will visually inspect proper placement of resident wheelchairs with appropriate fall devices 5 times per shift on a weekly basis. The DNS will report findings to the QAPI Committee monthly.2. All</p>	04/09/2014			

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	<p>(MDS) Significant Change Assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (1). A score of (1) indicated the resident's cognitive patterns were severely impaired. The MDS assessment indicated the resident required extensive assistance (resident involved in activity, staff provide guided maneuvering of limbs or other weight bearing assistance) of two or more staff members for transfers and locomotion on the unit (how the resident moves between locations in his/her room and adjacent corridor on the same floor). The assessment also indicated the resident had one fall since Admission/Entry or Reentry or Prior Assessment. The assessment indicated the resident had no injury with the fall.</p> <p>Review of the 1/25/14 Quarterly Inter Disciplinary Resident Review indicated the resident's Fall Risk assessment score was (12). A score of 10 or higher indicated the resident was at risk for falls.</p> <p>The 2/2014 Nursing Progress Notes were reviewed. A Change in Condition note was completed on 2/9/14 at 8:42 p.m. The note indicated the resident was found on</p>		<p>nursing staff were re-instructed on placement of falls interventions and use of CNA Assignment Sheets. The DNS and/or designee will visually insptect placement of fall interventions 5 times per unit on a weekly basis (beyond the visual inspections listed above). The DNS will report findings to the QAPI Committee monthly. Step Four: The results of the audit for proper placement of fall interventions including wheelchairs will be reviewed during the Clinical Start-Up Meeting weekly and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern) the results will be reviewed quarterly.</p> <p>Addendum: To assure privacy, Resident's wheelchairs are identified using a small name bracelet placed on the lowest part of the wheelchair frame.</p>		

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	<p>the floor next to the bed. The wheelchair was observed behind the resident and the resident was lying on her right side. No injury was noted to the resident's extremities or her head. The resident did not report any complaints of pain and was able to stand. A Nursing Progress note was completed on 2/10/14 at 2:04 a.m. This note indicated the resident had a bruise to the right posterior hand, the base of the right thumb, and she denied any pain. A Nursing Progress note completed on 2/10/14 at 9:32 a.m., indicated a bruise was noted to the upper right forehead at the hairline. Neurological checks were initiated and within normal limits. The Physician was notified of the bruise to the forehead.</p> <p>A Change in Condition Note was completed on 2/15/14 at 7:40 p.m. The note indicated the resident was observed face down and laying flat on the floor in the hallway. Blood was on the floor and the resident was telling staff to get her up. Lacerations were noted to the center of the resident's forehead and the bridge of her nose. The laceration to the resident's nose was 1.5 cm (centimeters) x 0.2 cm and the laceration to her forehead was 0.2 cm x 0.2 cm. The resident had a bloody</p>			
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	<p>nose and stated her nose was a little sore.</p> <p>The 2/2014 Wound Evaluation Flow Sheets were reviewed. The following Wound Evaluation Flow Sheets were reviewed:</p> <p>A Wound Evaluation Flow Sheet was initiated on 2/15/14 for a laceration to the forehead. The laceration measured 0.2 cm x 0.2 cm. A Physician's order was obtained to apply Bacitracin (an antibiotic) ointment to the area.</p> <p>A Wound Evaluation Flow Sheet was initiated on 2/15/14 for a laceration to the bridge of the resident's nose. The laceration measured 1.5 cm x 0.2 cm. A Physician's order was obtained to apply Bacitracin to the area.</p> <p>A Wound Evaluation Flow Sheet was initiated on 2/15/14 for a raised bruise to the forehead. The area measured 1.6 cm x 3.0 cm.</p> <p>A IDT (Inter Disciplinary Team) note was completed on 2/10/14 at 11:40 a.m. The note indicated the resident's fall which occurred on 2/9/14 was reviewed. The resident was noted to be on the floor in front of her wheelchair. Current fall</p>			
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	<p>interventions included anti-roll backs to the wheelchair. IDT recommended a Dycem (a pad to prevent sliding or slipping) be placed on the seat of the wheelchair.</p> <p>A Post Fall Investigation/Plan report was completed on 2/10/14. The report indicated the resident slid out of the wheelchair on 2/9/14 at 8:27 p.m.. The resident was attempting to self transfer herself. The report indicated the resident had a history of falls and displayed impaired safety awareness and judgment. The report indicated current fall interventions in place at the time of the fall included, anti rollbacks (devices attached to the back of a wheelchair to prevent the wheelchair from tipping back), non skid socks in bed, non skid shoes, and to keep the resident's call light in reach. The new recommendation made was for a Dycem to be added to the resident's wheelchair.</p> <p>A Post Fall Investigation/Plan report was completed on 2/17/14. The report indicated the resident fell on 2/15/14 at 7:40 p.m. The report indicated the resident slid out of her wheelchair and was attempting to self transfer prior to the fall. The report indicated the resident had a history of falls and displayed impaired safety</p>			
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	<p>awareness and judgment. The report indicated the resident sustained lacerations and bruises/redness after the fall. The report indicated resident's mediations were reviewed and the environment was checked for hazards. The resident stated she "stood up and slipped..." The report also noted the resident was in a wheelchair that was not hers. Recommendations made after the fall included to have Physical Therapy provide chair adjustment with roll backs and apply a chair alarm short term.</p> <p>When interviewed on 3/27/14 at 3:30 p.m., the Restorative Nurse indicated the 2/9/14 and the 2/15/14 falls were reviewed. The Restorative Nurse indicated at the time of the 2/9/14 the resident had anti-roll backs in place to her wheelchair and the new intervention added was for the resident to have Dycem placed on her wheelchair seat. The Restorative Nurse also indicated at the time of the 2/15/14 the resident was not in her wheelchair. The Restorative Nurse indicated the wheelchair the resident was in did not have anti-roll backs attached and did not have Dycem in place. The Restorative Nurse indicated staff looked for the resident's wheelchair</p>						

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	<p>and were not able to locate the wheelchair that day. The Restorative Nurse indicated at times the resident could transfer herself.</p> <p>2. On 3/27/14 at 8:35 a.m. and 10:35 a.m., Resident #F was observed in bed. The resident was awake. The resident had a sling in place to each arm. The resident's bed was not in the low position. The bed was approximately (2) feet from the ground. One side of the bed was up against the wall. No floor mat was in place next to the other side of the bed. There were no non skid strips on the floor next to the bed. There were no staff members or visitors in the room.</p> <p>The record for Resident #F was reviewed on 3/27/14 at 10:40 a.m. The resident's diagnoses included, but were not limited to, generalized pain, depressive disorder, Alzheimer disease, and chronic airway obstruction.</p> <p>Review of the 2/27/14 Minimum Data Set (MDS) Quarterly Assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (6). A score of (6) indicated the resident's cognitive patterns were severely impaired. The assessment</p>			
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	<p>also indicated the resident required supervision of one staff member for bed mobility and transfers. The assessment indicated the resident used a walker for mobility.</p> <p>A care plan initiated on 2/13/2012 indicated the resident was at risk for falls related to a diagnosis of Alzheimer's Disease and receiving anti-depressant medication. The care plan was revised with a goal date of 6/10/14. New interventions initiated on 3/4/14 included placing the resident on the Falling Leaf program and implementing the use of non-skid shoes/socks. New interventions initiated on 3/20/14 included the use of a low bed with a mat.</p> <p>The 3/2014 Nursing Progress Notes were reviewed. A Change in Condition entry was made on 3/13/14 at 8:44 a.m. This entry indicated staff responded to the call light alarming in the resident's bathroom. The resident was found sitting on the bathroom floor with her legs straight out in front of her. The resident was facing the sink. The resident stated her stomach and both her arms hurt. The resident's right forearm was externally rotated and she was unable to move her right arm. The</p>				

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	<p>resident also complained of pain to the left wrist and shoulder and pain was noted with movement of the left arm. The resident became pale and diaphoretic (sweating). The Physician was notified and orders were received to send the resident to the hospital Emergency Room. 911 was called and the resident was sent to the hospital.</p> <p>An entry made on 3/19/14 at 6:51 p.m., indicated the resident returned from the hospital with both of her arms in slings. The entry also indicated the resident had bilateral humerus (arm bone) fractures. The entry also indicated the resident's right arm was also in an immobilizer and was more swollen then the left as the right arm had been surgically repaired</p> <p>An entry made on 3/20/14 at 9:11 a.m. indicated the IDT (Inter-Disciplinary Team) met upon the resident's return to the facility after being hospitalized related to a fall. The IDT recommended the use of a low bed with a mat.</p> <p>The Resident Information Sheet for the resident's unit was reviewed on 3/27/14 at 11:00 a.m. The Unit Manager provide the sheet and</p>			
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	<p>indicated it was current. The Resident Information Sheet indicated Resident #F required extensive assistance of two staff members for transfers. The sheet also indicated the resident's right and left arms were fractured and the resident was to be in a low bed with a mat in place.</p> <p>When interviewed on 3/27/14 at 11:00 a.m., the Director of Nursing indicated Resident #F had recently been hospitalized for fractures of the both of her arms. The Director of Nursing indicated initial report from the hospital indicated the resident had a fracture to one of her arms and a suspected fracture of the other. The Director of Nursing indicated the hospital confirmed the fracture of the other arm at a later date. The Director of Nursing indicated the IDT meet to review the resident's fall on 3/20/14. At that time the IDT recommended the use of a low bed and a floor mat. The Director of Nursing indicated these interventions were to be in place. The Director of Nursing indicated the resident had resided on another unit at the time of her fall and was transferred to her current unit/room upon readmission from the hospital.</p> <p>When interviewed in Resident #F's</p>			
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	<p>room on 3/27/14 at 11:05 a.m., the Director of Nursing indicated the resident's bed was not currently in the lowest position and the bed was able to be lowered closer to the floor with the current bed controls. The Director of Nursing of Nursing indicated she did no see the floor mat in the resident's room at this time.</p> <p>When interviewed on 3/27/14 at 11:10 a.m., the Unit Manager indicated the resident's bed was to be low and a floor mat should have been in place when the resident was in bed.</p> <p>When interviewed on 3/27/14 at 11:45 a.m., CNA #1 indicated she was assigned to care for Resident #F at the start of her shift this morning. The CNA indicated she had taken of the resident when she resided on another unit. The CNA indicated this was the first day she had been assigned to care for Resident #F since she had been transferred to her current unit. The CNA indicated she was requested to transfer over to another unit sometime this morning. CNA #1 indicated the resident was awake and in bed when she first provided care. The CNA indicated she set the resident up for breakfast and she was able to feed herself. The</p>			
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	<p>CNA indicated she later helped the resident wash up, combed her hair, and changed her gown. CNA #1 indicated it was not reported to her that the resident was to have low bed or a floor mat. The CNA indicated she did not see a floor mat in the room when she provided care to the resident. The CNA indicated she recalled lowering the resident's bed after care but was "not sure" if she lowered it "all the way." CNA #1 also indicated she did have a Assignment sheet with her but was not sure if she "pay it any attention."</p> <p>3.1-45(a)(2)</p>			
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