STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-VALPARAISO	251 STURDY RD VALPARAISO, IN 46383

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F000000	This visit was for the Investigation of Complaints IN00127622 and IN00128019. Complaint IN00127622-Substantiated.Federal/state deficiencies related to the allegations are cited at F282 and F 314. Complaint IN00128019-Substantiated.Federal/state deficiencies related to the allegations are cited at F282 and F 314. Survey dates: April 30, and May 1, 2013 Facility number: 000062 Provider number: 155137 AIM number: 100271400 Survey team: Christine Fodrea, RN TC Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 4 Medicaid: 60 Other: 9 Total: 73	F000000	F0000Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 3, 2013 by Randy Fry RN.			

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F000282 SS=D	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.			
	Based on interview and record review the facility failed to follow physician orders for wound treatment for 2 of 3 residents reviewed for wound treatment completion in a sample of 3. (Resident #D, and Resident #E) Findings include: 1. Resident #D's record was reviewed 4-30-2013 at 10:30 AM. Resident #D's diagnoses included, but were not limited to, dementia, Parkinson's disease, and seizure disorder. A physician's order dated 6-20-2012 indicated the area on Resident #D's head was to be cleansed twice daily with normal saline, patted dry, and Betadine applied around the area of the stimulator wires. the area was to be covered with 2 x 2 gauze. A review of Resident #D's Treatment Record (TAR) dated January 2013 revealed the betadine treatment to the areas on Resident #D's head had not been signed as completed on day shift January 1, 2, 3, 5, and 7; and on	F000282	F 282 It is the practice of this facility that services be provided by qualified person in accordance with the resident's plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: -Residents "D" and "E" are no longer at the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: -The residents who have the potential to be affected have been identified through chart review. No further action was needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: -Licensed nurses have been in-serviced on PointClickCare treatment order entry for wounds to include order type.-Licensed nurses in-serviced to verify placement of dressings every shift on eTAR-This is an on-going process How the corrective action(s) will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place. -Physician orders,	05/24/2013

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	evening shift on January 11. In an interview on 4-30-2013 at 3:20 PM, LPN #1 indicated whenever a treatment was done, the TAR was initialed indicating the treatment had been completed. LPN #1 further indicated she had worked two days in that period, but had not signed the record. She was unable to recall if she had completed the treatment or if the Nurse Practitioner (NP) had been in that day to complete it. LPN #1 indicated she usually signed her record whenever the treatments were completed. In an interview on 4-30-2013 at 3:46 PM, NP #2 indicated she had not seen Resident #D in January as their contract had expired. 2. Resident #E's record was reviewed 4-30-2013 at 2:50 PM. Resident #E's diagnoses included end stage renal disease, diabetes, and ischemic heart disease. A physician's order dated 3-27-2013 indicated to discontinue Calmoseptine ointment to area on the left upper thigh and to cleanse the wound with wound cleanser, pat dry, apply Santyl ointment, and cover with Allevyn foam every other day.		including wound treatment orders and documentation will be audited 5 x week x 8 weeks, then 3 x week for 8 weeks, then weekly x 8 weeks by Clinical Manager or designee -Information gathered from the audits will be forwarded to the QAPI Committee for review for a minimum of 6 months.-Trends or patterns noted will have action plans written and interventions implemented.-The Executive Director and DNS will oversee this process. By what date the systemic changes will be completed. May 24, 2013 We respectfully request a desk review.	

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	A review of Resident #E's March 2013 TAR indicated the Calmoseptine ointment had been discontinued, but there was no indication the order for the Santyl treatment had been transposed to the TAR. there was no indication on the TAR the treatment had been completed as ordered. The treatment should have been completed on the 27th, the 29th, and the 31st of March. A review of Resident #E's TAR dated April 2013 indicated the Santyl treatment was started on April 6th 2013. The treatment should have been completed on the 2nd and 4th of April, but the area to sign the treatment as complete was struck out on the record with an X. A review of Resident #E's Nurse's notes dated 3-27-2013 at 13:55 (1:55 PM) indicated the treatment had been changed and the the spouse was present and was informed of the change in treatment. The notes did not indicate the dressing was changed. Further nurse's notes do not refer to the wound or dressing changes until 3-30-2013 at 15:29 (3:29 PM). Those notes indicated a treatment had been completed to the right gluteal area as ordered. There			

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	was no indication the treatment had been completed to the left upper thigh. Nurse's notes then did not indicate a treatment had been completed to the left upper thigh until 4-4-2013 at 17:58 (5:58 PM) This note indicated the spouse was present and viewed the area during dressing change, but did not include what treatment had been applied. In an interview on 5-1-2013 at 9:38 AM, RN #3 indicated she had changed the dressing on 4-4-2013, but could not recall if she had changed the dressing on the other days it was required. RN #3 further indicated if the nurses changed the dressing, they should have signed for it on the TAR. Review of the Wound Evaluation Flow Sheet dated 3-27-2013 indicated the measurements of the upper left thigh wound were 1.8 cm (centimeters) x 1.7 cm x < (less than) 0.1 cm. the w wound was described as slightly peeling with yellow, dark brown center. Review of the Wound Evaluation Flow Sheet dated 4-3-2013 indicated the measurements for the left upper thigh area were 1.8 cm x 1.7 cm x < 0.1 cm. The wound was described as dry			

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	and peeling and the surrounding area is described as dry and peeling as well. Review of the Wound Evaluation Flow Sheet dated 4-10-2013 indicated the measurements for the left upper thigh area were 1.4 cm x 1.3 cm x < 0.1 cm. the area is described as within normal limits with a yellow center. In an interview on 5-1-2013 at 11:17 AM, the Director of Nursing (DON) indicated the order had been placed on the Nursing Administration report, but not on the TAR. A policy titled Skin Integrity Guideline dated 1-2011 provided by the DON indicated "physical observation reflects interventions are in place... DON or designee evaluates and observes wounds on a weekly basis" This Federal tag relates to complaint number IN 00127622 and IN 00128019. 3.1-35(g)(2)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to assess wound status for 2 of 3 residents reviewed for wound status assessment in a sample of 3. (Resident #E, and Resident #F) Findings include: 1. Resident #E's record was reviewed 4-30-2013 at 2:50 PM. Resident #E's diagnoses included end stage renal disease, diabetes, and ischemic heart disease. A review of Resident #E's Wound Evaluation Flow Sheet dated 3-6-2013 indicated Resident #E had developed a wound on the left lower inner thigh measuring 1.7 cm (centimeters) x 1 cm. There was no indication of depth. The areas of exudate, pain, and periwound were	F000314	F 314 It is the practice of this facility that treatments and services to prevent or heal pressure sores will be provided. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: - Resident "E" is no longer at the facility. -Resident "F" wound was reassessed on 5-1-2013 during survey by ADNS and wound evaluation flow sheet was updated to reflect descriptive peri wound assessment and shown to surveyor for review. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: -The residents who have the potential to be affected have been identified through chart review and corrected What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	05/24/2013

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	marked through and there was no documentation in those areas to indicate wound status. A review of nurse's notes dated 3-6-2013 did not indicate the status of the wound. In an interview on on 5-1-2013 at 8:42 PM, the Director of Nursing (DON) indicated the area on the left lower inner thigh was due to friction and shear from sitting in the wheelchair, and in the chair at dialysis. She then indicated the area moved to a pressure area due to continued sitting in the dialysis chair on a regular, ongoing basis. The DON indicated the assessment of the area was incomplete. 2. Resident #F's record was reviewed 5-1-2013 at 9:40 AM. Resident #F's diagnoses included, but were not limited to, Alzheimer's dementia, lung disease, and water on the brain. During an observation on 4-30-2013 at 11:41 AM, Resident #F was observed to have a blister irregularly bean shaped approximately 1.5 cm x 2 cm on the left lower thigh. The blister was observed to be filled with clear fluid. The surrounding tissue was pink, with a red unblanchable line		-Licenses Wound nurse with certification hired and will be orientated to Skin Integrity Guidelines -Licensed Nurses will be in-serviced on documenting status of wound utilizing Wound Evaluation Flow sheet -This is an on-going process How the corrective action(s) will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place. -DNS or RN clinical manager will observe wounds and wound flow sheet documentation on a weekly basis -Physician orders, including wound treatment orders and documentation will be audited 5 x week x 8 weeks, then 3 x week for 8 weeks, then weekly x 8 weeks.-Information gathered from the audits will be forwarded to the QAPI Committee for review for a minimum of 6 months..-Trends or patterns noted will have action plans written and interventions implemented.-The Executive Director and DNS will oversee this process. By what date the systemic changes will be completed. May 24, 2013 We respectfully request a desk review.	

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	extending from each end of the blister about 0.1 cm wide and 15 cm long. A review of the Wound Evaluation Flow Sheet dated 4-30-2013 indicated the blister was measured 1.2 cm x 2.2 cm. The blister was noted to be intact. and filled with clear fluid. The areas titled exudate and wound bed were marked through. the area titled periwound indicated the wound margins were documented as WNL and the surrounding tissue was documented as being WNL. There was no indication there was an unblanchable red area extending from each end of the blister. RN #3 was interviewed on 4/30/13 and indicated the area was the result of pants being scrunched up and putting pressure on the area because they were ill fitting. In an interview on 5-1-2013 at 10:03 AM, the DON indicated the nurse should have better documented the status of the wound. A policy titled Skin Integrity Guideline dated 1-2011 provided by the DON on 5-1-2013 at 11:18 AM indicated the "Licensed nurse would document weekly on all wounds using the Wound Evaluation Flow Sheet"			

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