

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/15/2013
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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F000000	<p>This visit was for the Investigation of Complaints IN00133510, IN00133670, IN00134242, and IN00134323.</p> <p>Complaint IN00133510-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00133670-Substantiated. Federal/state deficiency related to the allegation is cited at F282.</p> <p>Complaint IN00134242-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00134323-Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey dates: August 13,14, &amp; 15, 2013.</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Survey team: Janet Adams, RN, TC</p>	F000000		
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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>Caitlyn Doyle, RN August 13 &amp; 14, 2013 Heather Hite, RN August 13 &amp; 14, 2013 Jennifer Redlin, RN August 13, &amp; 14, 2013</p> <p>Census bed type: SNF/NF: 148 Total: 148</p> <p>Census payor type: Medicare: 20 Medicaid: 106 Other: 22 Total: 148</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 18, 2013, by Janelyn Kulik, RN.</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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 orders and plan of care were followed related to a sling not in place as ordered for 1 of 2 residents reviewed for fractures in the sample of 11. (Resident #C)</p> <p>Findings include:</p> <p>On 8/13/13 at 6:45 p.m., Resident #C was observed in bed. The resident was awake. The resident had a short sleeve hospital gown on. The resident did not have a sling in place to her right arm. No sling was observed in the bed. The resident's right arm was bent at a 90 degree angle across her chest and her fingers were closed in a fist. There were no staff members in the room at this time.</p> <p>On 8/13/13 at 8:30 p.m., the resident was observed in bed. The resident was awake and was still wearing the hospital gown and did not have any sling on her right arm. There were no</p>	F000282	<p>The facility will ensure that services provided or arranged by the facility for resident use are provided by qualified persons in accordance with each resident's written plan of care. Residents #C was affected by this alleged deficient practice. This residents' physician orders (see item#12) and care plans (see Item #2) were reviewed with special focus on her orders for "arm sling usage" and all directives were followed as written. All residents have the potential to be effected by this deficient practice. Care plans and physician orders were reviewed by facility Unit Managers.</p> <p>The facility staff nurses will be re-in-serviced by 9-14-13 on the proper way to interpret resident care plans and physician orders and on how to ensure that staff are providing care according to these guidelines Staff will complete Pre and Post Tests on this training materials to ensure their understanding of in-service material.</p> <p>The facility DNS or designee will conduct daily audits (5 times per week) of 10% of resident care plans (see Item#2) for a period of 30 days; then weekly audits of 10% of resident care plans for an additional</p>	09/14/2013	

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	<p>staff members in the room at this time. LPN #2 entered the resident's room. The LPN assessed the resident and noted the resident did not have a sling on the right arm. The sling was not observed in the resident's bed or on the floor. LPN #2 then opened the top drawer of the chest next to the resident's bed and removed a black sling from the drawer and placed it on the resident's right upper extremity. The LPN then placed the strap around the resident's neck.</p> <p>On 8/15/13 at 7:47 a.m. and 8:37 a.m., the resident was observed in bed. The resident was awake. The resident had a short sleeve hospital gown on. There was a small cold compress pack resting on the resident's right upper arm area. The resident's right arm was bent at a 90 degree angle across her chest and her fingers were closed in a fist. A black sling was rolled down over the resident's right forearm area. The sling was not strapped around the resident's neck to hold the arm in place. There were no staff members in the room at the above times.</p> <p>On 8/15/13 at 9:40 a.m., the resident was observed in bed. The resident was awake. The resident had a short sleeve hospital gown on. There was</p>		<p>period of 60 days and then a monthly audit will be conducted of 10% of resident care plans for an additional period of 90 days to ensure that staff are aware of and are following the directives as set forth by each resident's plans of care.</p> <p>The facility DNS or designee will conduct daily (5 times per week) reviews of physician orders for a period of 30 days to ensure that resident's are receiving their care as ordered (Item #12 -Resident Physician Orders Audit Tool). Then weekly audits will be conducted for an additional period of 60 day. Finally, the DNS or designee will conduct monthly audits of MD orders for a period of 90 days to ensure that residents doctors' orders are followed.</p> <p>Significant results from audits will be reviewed as part of the facilities Daily Stand Up Meeting to ensure that resident's needs are being promptly met as ordered by their physicians and per their Plans of Care.</p> <p>Audit results will be discussed as part of the facilities monthly QAPI meetings. Audit findings and trends will be reviewed as part of this QAPI meetings for a period of 6 months and thereafter decreased to an as needed basis as determined by the QAPI committee. Any patterns or trends will cause an Action Plan to be written and appropriate</p>		

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	<p>a small cold compress pack resting on the resident's right upper arm area. The resident's right arm was bent at a 90 degree angle across her chest and her fingers were closed in a fist. A black sling was rolled down over the resident's right forearm area. The sling was not strapped around the resident's neck to hold the arm in place. There were no staff members in the room at the above time.</p> <p>CNA #3 entered the resident's room at 9:41 a.m. The CNA observed the resident's arm at this time. The compress was in place to the right arm and the black sling remained on the lower part of the resident's arm and was not strapped around her neck.</p> <p>LPN #1 entered the resident's room at 9:44 a.m. The LPN removed the compress pack from the resident's right upper arm. The compress pack was not cold or cool to touch.</p> <p>The record for Resident #C was reviewed on 8/13/13 at 7:30 p.m. The resident's diagnoses included, but were not limited to, fracture of the humerus, aphasia (inability to talk), osteoporosis, and cerebral aneurysm.</p> <p>Review of the current Physician</p>		<p>interventions to be implemented.</p>				

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	<p>orders indicated there was an order for the resident to wear a sling to the right upper arm at all times. The order was initially obtained on 7/25/13. A care plan initiated on 7/29/13 indicated the resident had right arm fracture. Care plan interventions include for the resident to wear a sling to the right arm.</p> <p>The 8/1/13 significant change Minimum Data Set (MDS) full assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The MDS assessment also indicated the resident had functional limitations of both upper and both lower extremities. The assessment also indicated the resident required extensive assistance (resident involved in activity and staff provide weight- bearing support) for dressing and hygiene.</p> <p>An X-ray of the of the right humerus was completed on 7/27/13. The X-ray results indicated there was an oblique fracture involving the right proximal humeral shaft.</p> <p>When interviewed on 8/13/13 at 8:35 p.m. LPN #2 indicated she was</p>			

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	<p>assigned to take of Resident #C this shift. The LPN indicated the resident was to wear the sling at all times. LPN #2 indicated she was last in the resident's room around 7:00 p.m. to administer medications to the resident and the sling was not on at that time either.</p> <p>When interviewed on 8/15/13 at 9:42 a.m., CNA #3 indicated she assisted another staff member to reposition the resident for breakfast and the compress was in place and the sling was in the same location then that is was now.</p> <p>When interviewed on 8/15/13 at 9:45 a.m., LPN #1 indicated she was assigned to care Resident #C today. The LPN indicated she had not placed the compress pack on the resident's arm this morning. The LPN indicated the right arm sling was not on correctly.</p> <p>This federal tag relates to Complaint IN00133670.</p> <p>3.1-35(g)(2)</p>				

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F000323 SS=G	<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 record review and interview, the facility failed to ensure safety devices were in place for a resident identified as a fall risk. This resulted in the resident sustaining a fracture from a fall for 1 of 3 residents reviewed for falls in the sample of 11. (Resident #H)</p> <p>Findings include:</p> <p>The closed record for Resident #H was reviewed on 8/14/13 at 7:00 a.m. The resident's diagnoses included, but were not limited to, personal history of a fall, cerebral embolism with cerebral infarction, diabetes mellitus, and cataract.</p> <p>Review of the 8/2013 Physician orders indicated there was an order written on 8/1/13 at 11:15 p.m. for a floor mat to the bedside. An Immediate Plan of Care for Falls was initiated on 8/1/13. The care plan indicted the resident was at risk for falls related to having fallen in the past (30) days had cardiovascular,</p>	F000323	<p>The facility will ensure that each resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #H was affected by this alleged deficient practice. Upon this resident's return to the facility her safety and security needs will be re-assessed and an individual care plan will be developed and implemente.</p> <p>All residents have the potential to be affected by this alleged deficient practice. Resident medical records will be reviewed with special focus on residents who are at risk for falls. Any residents found to be at risk for falls were placed on the facility Fall Monitoring &amp; Prevention Program and had their Care Plans revised as needed. Facility Direct Care Staff will be re-in-serviced by 9-14-13 on the facilities Fall Monitoring &amp; Prevention Program. The facility DNS or designee will conduct daily ( 5 times per week) audits of all reported falls per the facilities QPI System. Residents who at risk for falls will assessed using the Falls Audit Tool (item #13) and</p>	09/14/2013			

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	<p>neuromuscular/functional, and perceptual health problems. Interventions to be in place included, bedside commode, wheel chair for long distances, floor mat, bed in low position, call light in reach, and on a toileting program.</p> <p>Review of the 8/1/13 admission Clinical Health Status assessment form indicated the resident was admitted from the hospital with current diagnoses of cerebral vascular accident (stroke) with right side hemiparesis (weakness), aphasia (unable to speak), and falls. The form also indicate the resident needed assistance with decision making, had right sided weakness, shuffle type gait, unsteady balance with sitting and standing, and was dependent on staff for fluid intake. The "Risk for Falls" section indicated the resident had intermittent confusion, 1-2 falls in the past three months, was chair bound, and had lower extremity weakness. The resident's total score was (17). The scale indicated a total score of (10) or above deemed a resident at risk for falls.</p> <p>The 8/2013 Nursing Progress Notes were reviewed. A note entered on 8/2/13 at 7:04 a.m. indicated the CNA</p>		<p>all appropriate interventions will be implemented for a period of 30 days. Then weekly audits will be conducted for an additional period of 60 days and then monthly Fall Audits will be conducted for a final period of 90 days.</p> <p>Audit results and trends will be reviewed as part of the facilities Daily Stand Up Meeting to ensure that proper interventions are implemented in a timely manner. Significant audit results will also be reviewed at the facilities Monthly QAPI meetings. Audit findings will be reviewed in QAPI meetings for a period of 6 months and thereafter decreased to an as needed basis as determined by the QAPI committee. Any patterns or trends will cause an Action Plan to be written and appropriate interventions to be implemented.</p>		

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	<p>reported the new resident was on the floor. The entry also indicated the resident was laying on the floor by the bed and was confused. Two bruises were noted on the back of the resident's head. The resident displayed no facial grimacing, the Physician, and responsible party were notified. An entry made on 8/2/13 at 2:25 p.m. indicated the resident had hip pain, the Physician was notified, and an order was given to obtain an X-ray. An entry made on 8/2/13 at 3:12 p.m. indicated the results of the X-ray were received and noted a hip fracture. The Physician was notified and orders were obtained to transport the resident to the hospital.</p> <p>A 8/2/13 Radiology Report indicated a right hip X-ray was completed. The results of the X-ray indicated there was an acute right femoral neck fracture.</p> <p>A Verification of Investigation report was completed on 8/2/13. The report indicated the CNA reported the resident was on the floor. The time of the occurrence was listed as 2:30 a.m. The assessment of the resident indicated the resident was seen laying on her back by her bed, two bumps with bruising were found on the back of her head. The areas measured 4</p>			

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	<p>cm (centimeters) in diameter and 3 cm diameter. The "Immediate Resident Protection Initiated" section included to put a floor mat by the bed.</p> <p>When interviewed on 8/14/13 at 8:52 a.m., the Director of Clinical Education indicated the resident's fall occurred around 2:30 a.m. The Director indicated she had interviewed the CNA and the CNA told her the resident's bed was low to the ground at the time and a padded floor mat was implemented.</p> <p>When interviewed on 8/14/13 at 9:40 a.m., the Director of Clinical Education indicated she spoke with the Nurse who was assigned to care for the resident at the time of the 8/2/13 fall. The Director indicated the Nurse verified there was no mat on the floor at the time of the resident's fall.</p> <p>This federal tag relates to Complaint IN00134323.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>						