STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00105751. Complaint IN00105751 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157. Unrelated deficiencies cited. Survey dates: March 29 & 30, 2012 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Survey team: Mary Jane G. Fischer RN Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 16 Medicaid: 58 Other: 14 Total: 88 Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

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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	Quality review completed 4/4/12 by Jennie Bartelt, RN.			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, record review and interview, the facility failed to ensure the physician was notified of new wounds and decline in wounds for 2 of 2 residents with wound care needs in a sample of 3.	F0157	**Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report.**	04/27/2012

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	[Residents "C" and "A"]. The facility also failed to ensure the family was notified of the ongoing decline of a wound for 1 of 2 residents with wound care needs in a sample of 3. [Resident "A"]. Findings include: 1. The record for Resident "C" was reviewed on 03-30-12 at 10:15 a.m. Diagnoses included, but were not limited to, respiratory failure, atrial fibrillation, anorexia, diabetes mellitus, and encephalopathy, and the resident had surgical wounds to the right and left buttocks. These diagnoses remained current at the time of the record review. During observation on 03-30-12 at 10:00 a.m., Registered Nurse employee #7 was changing the dressing to the surgical wound on the right buttock using acetic acid solution, gauze and a transparent dressing, when she noticed the wound on the left buttocks and a wound adjacent wound to the right buttocks. During interview at this time, Registered Nurse employee #7 indicated she was unaware of the two other areas and proceeded to treat the wounds with the same physician ordered treatment as the first wound [right buttock] without physician notification for possible intervention of the new area		**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.** F157Corrective action: Resident “A” no longer resides at facility. Resident “C’s” physician and family were notified of current status of skin integrity and orders were verified for areas located on left and right buttock. Other residents affected: No other resident was identified as being affected by the alleged deficient practice. Systemic changes: Licensed nurses were re-educated on proper procedures for family and physician notification per facility policy. Monitoring: DNS or designee will monitor changes in resident condition on all shifts five times a week for two weeks; two times a week for four weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter to ensure proper family and physician notification is completed. DNS or designee will review for trends and patterns. Any concerns will be taken to QAA for review. Date of Completion: April 27, 2012	

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	noticed adjacent to the existing wound on the right buttock. 2. The clinical record for Resident "A" was reviewed on 03-29-12 at 1:20 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, transient ischemic attack with residual deficits, left hemiplegia and aphasia. These diagnoses remained current at the time of the record review. The physician re-write orders for November 2011 indicated an order as follows: "Adaptive Equipment [underscored] Patient to wear Swedish knee brace and AFO [an orthotic] during transfers and ambulation." This order was dated 09-07-11. The Wound Care Service Nurse Practitioner Progress Notes, dated 11-14-11, indicated the resident was being seen by the local Wound Care Service that came to the facility for an existing pressure wound on the sacral area. The "Wound Care Progress Note - First Visit," dated 11-21-11, indicated the resident had an "unstageable pressure area to the left med [medial] lower extremity, date of etiology 11-19-11," and the area was identified as "device related." The			

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	Progress Note further indicated the area had 100 % necrotic tissue and measured 5.7 cm. in length by 1.0 cm. in width by 0.1 cm. depth. The "Wound Evaluation Flow Sheet," dated 11-28-11, indicated the pressure area to the left calf was caused by "trauma." The Physical Therapy Progress Report, dated 12-04-11, indicated the "left leg wound measures 7.8 cm [length] by 2.1 cm [width] and 100 % black necrotic. Used left AFO [orthotic] and modification made with fleece padding to prevent pressure to the wound area." The record indicated the Wound Care Service Nurse Practitioner continued to evaluate and treat the area through 12-19-11 when the area measurements increased in size to 8.8 cm in length by 4.8 cm in width by 0.1 cm in depth. The "Wound Care Progress Note," dated 12-27-11, again indicated the area was "device related" and now measured 9.8 cm in length by 4.0 cm in width by 0.1 in depth. The notation indicated the resident's condition was discussed with the Director of Nurses and Physical Therapy. The notation indicated the Nurse Practitioner was "called by the			

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	DON [Director of Nurses] to eval. [evaluate] LLE [left lower extremity] wound for increase in deterioration and concern for poss. [possibility] necrotizing fasciitis, increased drainage, purulence, erythema and pain noted. Will need debrided ... start ATB [antibiotic] treatment intravenously and will need to soften eschar before proceeding." The "Physician Order Sheet," also dated 12-27-11, instructed the nursing staff to "Call for issues or concerns." Subsequent measurements documented by the Wound Care Nurse Practitioner were as follows: "12-29-11 - 10.1 cm in length by 3.6 cm in width by 0.1 cm in depth." "01-09-12 - two areas now identified #1 - 11.2 cm in length by 3.8 cm in width by 0.1 cm in depth, #2 1.4 cm in width by 0.4 cm in width and 0.1 cm in depth." The area was debrided on this date. "01-20-12 - #1 12.0 cm in length by 6.0 cm in width by 0.3 cm in depth. The notation indicated an "arrow" to the section for notations on #2 as one wound an unstageable stage 3 [full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed] "with a large amount of exudate,			

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	tenderness, warmth erythema and maceration." The handwritten note at the bottom of this assessment indicated, "Recommend LTAC [long term acute care hospital setting] admission for deterioration of wound and general decline in condition. Peri wound cellulitis apparent at this time." The Wound Care Service Nurse Practitioner Progress Notes related to "discussion" with referring physicians in regard to "agree / disagreed / orders written / or asked me to follow," for visits dated 11-28-11, 12-05-11, 12-12-11, 12-19-11, 12-27-11, 12-29-11, and 01-09-12 were blank and indicated the wounds were discussed with the facility "wound nurse." The Physician Order Sheet, dated 01-20-12, instructed the nursing staff to "Transfer to [name of local area hospital] pending family approval - ind. [indication] failure lower level of care." The resident's medical record at the local area hospital record was reviewed on 03-29-12 at 10:20 a.m. Admission documentation for hospitalization on 1/20/12, indicated the resident had a "necrotic area left med. calf with tendon exposed" which measured "11.6 cm [length] by 4.5 cm [width] by 0.6 cm			

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	[depth]." The hospital Admission History and Physical, dated 01-20-12, indicated the following: "[Resident] has a dressing on left posterior calf. When removed has two areas that are packed with gauze dressing. The wound is draining yellow purulent drainage." The handwritten "Physician Progress Note," dated 01-20-12 indicated the resident was "at risk for amputation secondary to wound." During interview on 03-30-12 at 4:00 p.m., the Director of Nurses and Patient Care Coordinator were unable to provide documentation that the resident's primary physician was aware of the continued decline in the resident's pressure wound or the family was kept informed of condition and treatment changes by the wound care nurse practitioner or facility nursing staff. 3. Review of the facility policy on 03-29-12 at 1:00 p.m., titled "Notification of Change in Resident Health Status," and undated indicated the following: "The facility will consult the residents physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is: (B) Acute illness or a significant change in the resident's physical, mental, or			

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	psychosocial status (i.e. a deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications). Criteria: Life threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage 2 pressure sore when no ulcers were previously present at stage 2 or higher, onset or recurrent periods of delirium, recurrent urinary tract infection, or persistent decline in psycho social status. Appropriate notification time: immediate." "(C) A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)." "(D) A decision to transfer or discharge the resident from the facility. Criteria: Appropriate notification time, immediate." "Nursing judgement is an integral part of the skilled care provided in this facility, therefore, such judgement must be applied in a case by case basis in keeping with acceptable nursing practice." "Definition: Immediate [bold type] - As soon as possible no longer than 24 hours."			

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	This federal tag relates to IN00105751. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0282 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 observation, record review and interview, the facility failed to ensure a physician's order was followed, in that when a resident who had surgical wounds and specific physician orders for treatment to the areas, the nursing staff failed to provide the wound care treatment as prescribed by the physician for 1 of 3 residents reviewed for wound care. [Resident "C"]. Findings include: The clinical record for Resident "C" was reviewed on 03-30-12 at 10:15 a.m. Diagnoses included, but were not limited to, respiratory failure, atrial fibrillation, anorexia, diabetes mellitus, and encephalopathy. These diagnoses remained current at the time of the record review. On 03-30-12 at 9:40 a.m., two Registered Nurses [employees #7 and #8] were observed in the resident's room. During interview at this time, Registered Nurse employee #7 indicated she was preparing to "clean" the resident and then change	F0282	F282 Corrective action: Resident “C’s” wound care orders were reviewed and verified for clarity. Other residents affected: No other resident was identified as being affected by the alleged deficient practice. Systemic changes: Licensed nurses were re-educated on proper procedures for following physician’s orders for wound treatment administration. Certified Nurses Aides were re-educated on need for nurse notification if wound dressing is found to be soiled or not intact. Monitoring: DNS or designee will observe wound treatment administration on all shifts as ordered by physician five times a week for two weeks; two times a week for four weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter to ensure proper physician treatment orders are followed appropriately. DNS or designee will monitor pericare of residents with wound treatment orders five times a week for two weeks; two times a week for four	04/27/2012

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	the dressing to the resident's surgical wound. The door to the resident's room was closed and curtain drawn. Registered Nurse employee #8 turned the resident to the left side, while Registered Nurse employee #7, cleaned stool from the resident's buttocks. While care was being delivered, and as Registered Nurse employee #7 cleaned the stool from the resident's buttocks, an area was observed on the right buttock. A dressing was not present. Registered Nurse employee #7 indicated, "If [resident] was changed during the night shift, they may not have put another dressing over the area." Registered Nurse employee #7 continued to provide care and then indicated she was ready to start the treatment to the area. Registered Nurse employee #7 indicated she had a 10 c.c. [cubic centimeters] syringe with acetic acid solution in it and instilled the acetic acid solution into the wound, while dabbing the solution which had spilled from the area of the wound. Registered Nurse employee #7 then placed a dry piece of gauze over the wound and attempted to cover the area with a transparent dressing. She then indicated the treatment was complete. However, upon further inspection the wound was covered only by the		weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter to ensure treatments are in place and necessary notification to nurse in observed otherwise. DNS or designee will review for trends and patterns. Any concerns will be taken to QAA for review. Date of Completion: April 27, 2012	

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	transparent dressing without the protection of the gauze. Registered Nurse employee #7 indicated she needed to "redo" the dressing change. Registered Nurse employee #8 indicated she would obtain additional supplies and exited the resident's room. A Certified Nurses aide [employee #9] entered the resident's room and indicated she would assist with turning the resident, as Registered Nurse employee #8 had to assist another resident. The Certified Nurses Aide employee #9 turned and cradled the resident to the right side. As the Certified Nurses Aide employee #9 positioned the resident so Registered Nurse employee #7 could do the wound care, an additional wound was observed on the resident's left lower buttocks and a superficial area adjacent to the original wound observed on the resident's right buttock. During this observation Registered Nurse employee #7 indicated she was unaware of the two other areas and repeated the same treatment as previously observed with the acetic acid solution, gauze and transparent dressing to all areas. The resident's record indicated a physician order, dated 03-28-12 for the following: "Acetic Acid (0.25%) (Acetic Acid) 0.25% solution irrigation - two			

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	times a day everyday. Cleanse R/L [right and left] buttocks wounds with acetic acid, apply calazime cream to peri wounds, apply Saf-Gel Fluff gauze to wound bed and secure with transparent drsg. [dressing] BID [two times a day]." The Registered Nurse employee #7 failed to follow the physician order for the calazime cream and the Saf-Gel Fluff gauze to the wound bed prior to placing the transparent dressing over the area. During an observation on 03-30-12 at 2:00 p.m., the wound areas were measured with the Director of Nurses and the Patient Care Coordinator [Licensed Nurse employee #4]. The Patient Care Coordinator employee #4 indicated the following measurements of the areas: "Right upper buttocks 1.3 cm [centimeters] in length by 1.1 cm in width, Left buttocks 1.0 cm in length by 1.0 cm in width, and the area adjacent to the original area on the right buttock was measured at 1.0 cm in diameter." 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to ensure nursing staff were aware of and followed the physician's orders related to care of surgical wounds for 1 of 3 residents reviewed for wound care in a sample of 3. [Resident "C"]. The resident's wounds were observed without the ordered dressing in place, the nurse providing care was not aware the resident had two wounds, and she dressed only one wound, the cream ordered for the wound care was not applied as ordered, and the transparent dressing was placed directly on the wound instead of over the gauze on the wound. Findings include: The record for Resident "C" was reviewed on 03-30-12 at 10:15 a.m. Diagnoses included, but were not limited to, respiratory failure, atrial fibrillation, anorexia, diabetes mellitus, and encephalopathy. These diagnoses remained current at the time of the record review.	F0309	F309Corrective action: Resident "C's" wound care orders were reviewed and verified for clarity and wound care was redone per physician orders. Systemic changes: Licensed nurses were re-educated on proper procedures for following physician's orders for wound treatment administration. Certified Nurses Aides were re-educated on need for nurse notification if wound dressing is found to be soiled or not intact. Monitoring: DNS or designee will observe wound treatment administration on all shifts as ordered by physician five times a week for two weeks; two times a week for four weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter to ensure proper physician treatment orders are followed appropriately. DNS or designee will monitor pericare of residents with wound treatment orders five times a week for two weeks; two times a week for four weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter	04/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/30/2012
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	During an interview on 03-29-12 at 12:45 p.m., the resident's family member indicated the resident had difficulty swallowing, "but needs to because now [resident] has a sore on [resident] backside because [resident] doesn't eat." During this interview, the resident's family member was seated adjacent to the resident's bed. The resident was observed lying on back with head elevated. The resident's family member indicated, "Now [resident] has a special mattress to help [in regard to aiding in the healing of the wound]." On 03-30-12 at 9:40 a.m., two Registered Nurses [employees #7 and #8] were observed in the resident's room. During interview at this time, Registered Nurse employee #7 indicated she was preparing to "clean" the resident and then change the dressing to the resident's wound. The door to the resident's room was closed and curtain drawn. Registered Nurse employee #8 turned the resident to the left side, while Registered Nurse employee #7, cleaned stool from the resident's buttocks. While care was being delivered, and as Registered Nurse employee #7 cleaned the stool from the resident's buttocks, an area was observed on the right buttock. A dressing was not		to ensure treatments are in place and necessary notification to nurse in observed otherwise. DNS or designee will review for trends and patterns. Any concerns will be taken to QAA for review. Date of Completion: April 27, 2012	

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	present. Registered Nurse employee #7 indicated, "If [resident] was changed during the night shift, they may not have put another dressing over the area." Registered Nurse employee #7 continued to provide care and then indicated she was ready to start the treatment to the area. The Registered Nurse employee #7 indicated she had a 10 c.c. [cubic centimeters] syringe with acetic acid solution in it, and she instilled the acetic acid solution into the wound, while dabbing the solution which had spilled from the area around the wound. Registered Nurse employee #7 then placed a dry piece of gauze over the wound and attempted to cover the area with a transparent dressing. Registered Nurse employee #7 indicated the treatment was complete. However, upon further inspection, the wound was covered only by the transparent dressing without the protection of the gauze, and then she indicated she needed to "redo" the dressing change. Registered Nurse employee #8 indicated she would obtain additional supplies and exited the resident's room. A Certified Nurses Aide [employee #9] entered the resident's room and indicated she would assist with turning the resident, as Registered Nurse employee #8 had to			

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	assist another resident. The Certified Nurses Aide employee #9 turned and cradled the resident to the right side. As the Certified Nurses Aide employee #9 positioned the resident so Registered Nurse employee #7 could do the wound care, an additional wound was observed on the resident's left lower buttocks, and a superficial area adjacent to the original wound was observed on the resident's right buttock. During this observation Registered Nurse employee #7 indicated she was unaware of the two other areas, and she then repeated the same treatment as previously observed with the acetic acid, gauze and transparent dressing over the entire area which included both right and left buttocks. The resident's record indicated a physician order dated 03-28-12 for the following: Acetic Acid (0.25%) (Acetic Acid) 0.25% solution irrigation - two times a day everyday. Cleanse R/L [right and left] buttocks wounds with acetic acid, apply calazime cream to peri wounds, apply Saf-Gel Fluff gauze to wound bed and secure with transparent drsg. [dressing] BID [two times a day]." During an observation on 03-30-12 at 2:00 p.m., the resident's wound areas were measured with the Director of Nurses and the Patient Care Coordinator [Licensed			

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	Nurse employee #4]. The Patient Care Coordinator employee #4 indicated the following measurements of the areas: "Right upper buttocks 1.3 cm [centimeters] in length by 1.1 cm in width, Left buttocks 1.0 cm in length by 1.0 cm in width, and the area adjacent to the original area on the right buttocks was measured at 1.0 cm in diameter." 3.1-37(a)			