

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  01/06/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00161450 and IN00161505.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00162068.</p> <p>Complaint IN00161450 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00161505 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: December 29, 30, &amp; 31, 2014 and January 2, 5 &amp; 6, 2015.</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Survey team: Heather Hite, RN, TC Julie Ferguson, RN Caitlyn Doyle, RN Jennifer Redlin, RN (12/29 - 12/31/14 &amp; 1/2/15) Janelyn Kulik, RN (1/2/14 and 1/3/15)</p>	F000000	<b>F000</b> - Preparation, 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 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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F000157 SS=D	<p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census Payor type: Medicare: 3 Medicaid: 65 Other: 6 Total: 74</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 12, 2015, by Janelyn Kulik, RN.</p> <p>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</p>			
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	<p>of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a cognitively impaired resident's family of a change in a medication treatment, and order for labs, and a urine analysis that was completed for 1 of 1 residents reviewed for notification of change in condition. (Resident #82)</p> <p>Findings include:</p> <p>Interview with the resident's husband on 12/30/14 at 9:17 a.m., indicated he was not notified of any changes for the resident in medications or treatments. He indicated he was not told that his wife was "contagious" until he visited on Christmas Day. He further indicated he would be the person notified for a change in the resident's condition.</p>	F000157	<p><b>F157</b> - 1) Resident #82's husband was notified of labs, medication changes and contact precautions. 2) All residents have the potential to be affected by the alleged deficient practice. 3) Nurse's were in-serviced on the policy for family notification. Notification/Care plan audit tool will be used in clinical start-up to verify that appropriate notifications have been completed. 4) An audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5) January 24, 2015</p>	01/24/2015

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	<p>The record for Resident #82 was reviewed on 12/31/14 at 2:23 p.m. The resident's diagnoses included, but were not limited to, dementia.</p> <p>The resident's Quarterly MDS (Minimum Date Set) assessment on 11/9/14 indicated the resident was cognitively impaired.</p> <p>A Physician Order dated 10/29/14 at 14:57 (2:57 p.m.), indicated obtain "UA/C&amp;S (Urine Analysis with Culture and Sensitivity), CBC (Complete Blood Count) and CMP(Comprehensive Metabolic Panel) on 10/30/14."</p> <p>Review of Nurse Progress Notes indicated a lack of documentation that the resident's family was notified of the Physician's Orders.</p> <p>Interview with ACU Unit Director on 12/31/14 at 2:53 p.m. indicated the family was not notified of the UA/C&amp;S and labs.</p> <p>A Physician's Order dated 12/16/14 at 13:09 (1:09 p.m.), indicated "Permethrin Cream 5% Apply neck to toe topically one time only for rash for 1 Day leave cream on for 8-12 hours then shower."</p>			

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	<p>The MAR (Medication Administration Record) for December 2014 indicated the Permethrin Cream was applied on 12/18/14 at 2308 (12:08 p.m.).</p> <p>Review of the Nurse Progress Note on 12/18/14 at 21:53 (9:53 p.m.) indicated the Permethrin Cream was applied by the nurse. Nurse Progress Note dated 12/19/14 at 13:03 (1:03 p.m.) indicated the resident was on contact precautions. The Nurse Progress Notes lacked documentation that the family had been notified of the medication treatment and the contact precautions.</p> <p>Interview with ACU Unit Manager on 12/31/14 at 2:37 p.m., indicated for resident's who are cognitively impaired, the families are notified of medication changes and any significant changes outside their normal behaviors. The nurses are to notify family of all medication changes. The ACU Unit Director further indicated Resident #82's husband was not notified of the medication treatment or the contact precaution and should have been.</p> <p>Interview with LPN #1 on 12/31/14 at 2:45 p.m., indicated the resident's family was not notified of the new orders or the contact precautions and he should have been.</p>			

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F000279 SS=D	<p>A facility policy titled "Notification of Change in Resident Health Status," dated 1/2/15, was received as current from the DON (Director of Nursing) at 8:35 a.m. The policy indicated, "...DEFINITIONS...Notifications: within 24 hours from the time an assessment has been made indicating there may be a potential for physician intervention. (B) Acute illness or a significant change in the resident's physical, mental or psychosocial status...(C) A need to alter treatment significantly...."</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as</p>			

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	<p>required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan for pain for 1 of 1 resident reviewed for deaths and failed to develop a care plan for Aspirin, for 1 of 5 residents reviewed for unnecessary medications . (Resident # 29 and Resident #92)</p> <p>Findings include:</p> <p>1. The closed record for Resident #29 was reviewed on 1/2/15 at 11:55 a.m. Diagnoses included, but were not limited to, chronic kidney disease, lipoma (tumor), dementia, delusions, psychosis, anemia (blood disorder), depression, generalized pain, chest pain, and hypertrophy prostate (enlarged prostate).</p> <p>Review of the POS (Physician Order Summary) dated 8/4/14 indicated Tramadol HCL (pain medication) tablet 50 mg (milligrams) give one tablet by mouth every 8 hours as needed for pain.</p> <p>Review of the MAR (Medication Administration Record) for August 2014 indicated Tramadol HCl was received on the following dates: 8/2, 8/3, 8/4 twice,</p>	F000279	<p><b>F279 -</b></p> <p>1) Resident #29 is deceased. Resident #55's care plans were reviewed and changes were made as needed.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. Residents on anti-platelet medication care plans were reviewed and/or put in place. All residents were reviewed for pain and care plans were put in place.</p> <p>3) Nurse's were in-serviced on initiating care plans when receiving new orders. Notification/Care plan audit tool will be used in clinical start-up to verify that appropriate notifications have been completed.</p> <p>4) An audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting.</p> <p>5) January 24, 2015</p>	01/24/2015

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	<p>8/9 twice, 8/10, 8/12 twice, 8/13, 8/14, 8/15, 8/17 twice, 8/18 twice, 8/19 and 8/20.</p> <p>Review of the Admission assessment on 7/29/14 indicated the resident had pain.</p> <p>The resident's record lacked a care plan for pain.</p> <p>Interview with the DON (Director of Nursing) on 1/2/15 at 3:40 p.m., indicated there was no care plan for pain and one should have been created for Resident #29.</p> <p>2. The record for Resident #92 was reviewed on 12/31/14 at 10:00 a.m. Diagnoses included, but were not limited to, hyperlipidemia, Diabetes Mellitus, hypertension (high blood pressure) and dementia.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 12/1/14 indicated the resident's was cognitively impaired.</p> <p>The POS dated 12/1/14 indicated, Aspirin tablet 81 mg (milligrams) by mouth one time a day. Start date 8/22/14.</p> <p>The record lacked a care plan for Aspirin.</p> <p>The Medication Administration Record</p>			

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F000282 SS=D	<p>for December 2014 indicated Aspirin was given as ordered.</p> <p>Interview with the DON (Director of Nursing) on 12/31/14 at 11:11 a.m., indicated there was no care plan for Aspirin and one should have been created for Resident #92.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>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 record review and interview, the facility failed to follow residents' plans of care related to proper supervision for transfers resulting in falls for 2 of 5 residents reviewed for accidents. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. The record for Resident #B was reviewed on 12/30/2014 at 1:15 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis of half of the body) due to cerebrovascular disease, depressive disorder, acute respiratory failure, arthropathy and Diabetes</p>	F000282	<p><b>F282</b> - 1) Teachable moments had been given to staff members at the time of the incidents who were involved with residents #B and #C. 2) All residents have the potential to be affected by the alleged deficient practice. Resident Care Plan sheets were reviewed and updated as needed. 3) Nurse's and CNA's were in-serviced on following Resident Care Plan sheets for proper transfers. Staff will be observed and audited randomly on all shifts for proper transfer according to Resident Care Plan sheets. 4) Transfer Audit tool will be completed by the DNS/designee 9 times per week</p>	01/24/2015

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	<p>Mellitus.</p> <p>Review of a Progress Note dated 10/12/14 at 09:14 (9:14 a.m.), indicated Resident #B was lowered to her bed in the low position from standing with her walker and 1 staff assist. The staff reported during this time the resident's right leg buckled "and was basically underneath her."</p> <p>Review of a Progress note dated 10/13/14 at 2:41 p.m., indicated an x-ray was done with "likely malleolar fracture."</p> <p>Review of the Fall care plan indicated: "At risk for falls related to: new environment, hx. [history] of falls, unsteady transfers ...."</p> <p>Review of the Fall Investigation dated 10/12/14, indicated, "Nurse was attempting to transfer res [resident] 1 person limited assist with walker, res (resident) (sic) leg started to buckle - nurse lowered bed and helped res back on bed rather than her falling on floor."</p> <p>A staff correction "Teachable Moment" form included in the fall follow-up indicated, "When working as a CNA or assisting residents to transfer, make sure you have your CNA sheet on you at all times and you transfer resident as the</p>		for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5) January 24, 2015				

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	<p>CNA sheet indicates."</p> <p>A nursing staff inservice note dated 10/13/14, indicated, "We had an incident where our resident was transferred differently then the CNA INFO sheet stated, which resulted in an injury. CNA must carry Info sheets on them at all times while working the floor ... CNAs and nurse must make sure you are transferring every resident per what is on the CNA INFO sheet. If the resident has had any change in ability to transfer, notify your nurse immediately so the resident can be assessed for change in condition. It takes everybody to keep the resident safe."</p> <p>The CNA Info Sheet for the date of the incident was not available for review.</p> <p>Interview with the DON on 01/05/2015 11:58 a.m., indicated staff, at the time of Resident #B's fall, should have been using a 2 person assist and only used a 1 person assist. The DON further indicated falls and transfer status were discussed in daily stand up meetings and it was decided there whether or not to change a status for a resident. Resident #B had been a 1 person assist previously, but had a lowering to the floor incident with therapy 2 days prior to her fall, so the resident was changed to a 2 person assist</p>						

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	<p>for staff. Transfer status was on the CNA info sheets and staff were to follow these. Employees were inserviced on the importance of following the CNA sheets after this incident.</p> <p>2. The record for Resident #C was reviewed on 1/6/15 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's, epilepsy, presenile dementia with delusional features, and psychosis.</p> <p>Review of a Progress Note dated 12/11/14 at 7:50 a.m., indicated a CNA was transferring Resident #C from the bed to the wheelchair in the standing position when the resident sat on the edge of the wheelchair and began to slide. The resident was lowered to the floor in the sitting position by the CNA. There was no injury noted.</p> <p>Review of the Fall care plan indicated, "Risk for falls r/t [related to] DX [diagnosis] progressive dementia with psychosis, resident resistive to care at times/ requires two person assist at times, hx of falls, requires staff assist to walk safely."</p> <p>Review of the Fall Investigation dated 12/11/14 indicated, "Description: Resident was being</p>			

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	<p>transferred from the bed to the wheelchair by CNA, resident was in the standing position and sat on the wheelchair. When resident sat on the wheelchair, resident began to slide. Resident was lowered to the floor by the CNA.</p> <p>Assessment: head to toe assessment completed, no injuries noted.</p> <p>Interview: Resident does not respond to questions</p> <p>Contributing factors: Resident was transferred one assist, resident is a two assist transfer.</p> <p>Recommendations: CNA instructed to follow the CNA sheet.</p> <p>Wearing shoes at the time of the fall."</p> <p>A staff correction "Teachable Moment" form included in the fall follow-up indicated, "It is mandatory to carry your CNA sheets with you at all times and follow all information in there that pertains to our residents. After education is received, you must follow CNA sheets, If it states a res (resident) is a one assist, it is okay to transfer that resident by yourself if able to do so. If it states "2 assist" you must have another staff member help you with the transfer for not only the safety of our resident but also yourself."</p> <p>The CNA Info Sheet for the date of the</p>			

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F000323 SS=G	<p>incident was not available for review.</p> <p>Interview with the DON on 01/06/2015 at 12:32 p.m. indicated, the CNA transferred Resident #C with only 1 assist when the resident was supposed to be a 2 assist per the CNA info sheet. She further indicated a "teachable moment" was done for this CNA since she has had no other issues, but if any other incidents of this nature happen with any staff, the staff member will be written up. She had done several inservices which discuss giving care as indicated and following CNA sheets.</p> <p>Interview with the South Unit Manager on 1/06/2015 at 12:45 p.m., indicated she had conducted the teachable moment training with the staff CNA involved in Resident #C's incident. She further indicated the CNA had transferred the resident by herself and should have had a second staff member according to the CNA info sheet.</p> <p>3.1-35(g)(2)</p> <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</p>						

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	<p>assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure proper supervision and assistance was provided while transferring a resident, resulting in a resident falling and obtaining an ankle fracture for 1 of 5 residents reviewed for falls and a fall with no injury for 1 of 5 residents reviewed for falls. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. The record for Resident #B was reviewed on 12/30/2014 at 1:15 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis of half of the body) due to cerebrovascular disease, depressive disorder, acute respiratory failure, arthropathy and Diabetes Mellitus.</p> <p>Review of a Progress Note dated 10/10/14 at 10:12 a.m., indicated Resident #B was standing with her walker and 1 therapy staff assist, using a gait belt, when her leg bent &amp; she slid to the floor with staff assist.</p> <p>Review of a Progress Note dated 10/12/14 at 9:14 a.m., indicated Resident #B was lowered to her bed in the low position from standing with her walker and 1 staff assist. The staff reported</p>	F000323	<p><b>F323</b> - 1) Teachable moments had been given to staff members at the time of the incidents who were involved with residents #B and #C. 2) All residents have the potential to be affected by the alleged deficient practice. Resident Care Plan sheets were reviewed and updated as needed. 3) Nurse's and CNA's were in-serviced on following Resident Care Plan sheets for proper transfers. Staff will be observed and audited randomly on all shifts for proper transfer according to Resident Care Plan sheets. 4) Transfer Audit tool will be completed by the DNS/designee 9 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5) January 24, 2015</p>	01/24/2015			

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	<p>during this time the resident's right leg buckled "and was basically underneath her."</p> <p>Review of a Progress Note dated 10/12/14 at 1:32 p.m., indicated, the resident was unable to transfer with a 1 person assist, complained of pain to her right calf, ankle and foot, and needed a 2 person maximum assist to transfer to bed.</p> <p>Review of a Progress note dated 10/13/14 at 2:41 p.m., indicated an x-ray was done with "likely malleolar fracture."</p> <p>Review of the Physician's Order Summary (POS) for all orders from 8/21/14 - 1/31/15 indicated the following orders:</p> <ul style="list-style-type: none"> <li>- NWB (non-weight bearing) to RLE (right lower extremity) for Medial Malleolus Fx. (11/18/14)</li> <li>- NWB to RLE in boot at all times except for hygiene - every shift for Medial Malleolus Fx. (10/23/14)</li> <li>- NWB to RLE in boot at all times when up, may remove while in bed if R foot is elevated - every shift for Medial Malleolus Fx. (10/28/14)</li> </ul> <p>Review of the Fall care plan indicated: "At risk for falls related to: new environment, hx. [history] of falls, unsteady transfers ...." It was updated to</p>			

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	<p>include medial malleolar fracture.</p> <p>Review of the Fall Investigation dated 10/12/14, indicated, "Nurse was attempting to transfer res [resident] 1 person limited assist with walker, res leg started to buckle - nurse lowered bed and helped res back on bed rather than her falling on floor."</p> <p>A staff correction "Teachable Moment" form included in the fall follow-up indicated, "When working as a CNA or assisting residents to transfer, make sure you have your CNA sheet on you at all times and you transfer resident as the CNA sheet indicates."</p> <p>A nursing staff inservice note dated 10/13/14, indicated, "We had an incident where our resident was transferred differently then the CNA INFO sheet stated, which resulted in an injury. CNA must carry Info sheets on them at all times while working the floor ... CNAs and nurse must make sure you are transferring every resident per what is on the CNA INFO sheet. If the resident has had any change in ability to transfer, notify your nurse immediately so the resident can be assessed for change in condition. It takes everybody to keep the resident safe."</p>			

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	<p>Interview with the DON on 01/05/2015 11:58 a.m., indicated staff, at the time of Resident #B's fall, should have been using a 2 person assist and only used a 1 person assist. She further indicated falls and transfer status were discussed in daily stand up meetings and it was decided there whether or not to change a status for a resident. Resident #B had been a 1 person assist previously, but had a lowering to the floor incident with therapy 2 days prior to her fall, so the resident was changed to a 2 person assist for staff. Transfer status was on the CNA info sheets and staff were to follow these. Employees were inserviced on the importance of following the CNA sheets after this incident.</p> <p>2. The record for Resident #C was reviewed on 1/6/15 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's, epilepsy, presenile dementia with delusional features, and psychosis.</p> <p>Review of a Progress Note dated 12/11/14 at 7:50 a.m., indicated a CNA was transferring Resident #C from the bed to the wheelchair in the standing position when the resident sat on the edge of the wheelchair and began to slide. The resident was lowered to the floor in the sitting position by the CNA. There was</p>			

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	<p>no injury noted.</p> <p>Review of the Fall care plan indicated, "Risk for falls r/t [related to] dx [diagnosis] progressive dementia with psychosis, resident resistive to care at times/ requires two person assist at times, hx of falls, requires staff assist to walk safely."</p> <p>Review of the Fall Investigation dated 12/11/14 indicated, "Description: Resident was being transferred from the bed to the wheelchair by CNA, resident was in the standing position and sat on the wheelchair. When resident sat on the wheelchair, resident began to slide. Resident was lowered to the floor by the CNA.</p> <p>Assessment: head to toe assessment completed, no injuries noted.</p> <p>Interview: Resident does not respond to questions</p> <p>Contributing factors: Resident was transferred one assist, resident is a two assist transfer.</p> <p>Recommendations: CNA instructed to follow the CNA sheet.</p> <p>Wearing shoes at the time of the fall."</p> <p>A staff correction "Teachable Moment" form included in the fall follow-up indicated, "It is mandatory to carry your</p>						

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F000328 SS=D	<p>CNA sheets with you at all times and follow all information in there that pertains to our residents. After education is received, you must follow CNA sheets, If it states a res [resident] is a one assist, it is okay to transfer that resident by yourself if able to do so. If it states "2 assist" you must have another staff member help you with the transfer for not only the safety of our resident but also yourself."</p> <p>Interview with the DON on 01/06/2015 at 12:32 p.m. indicated, the CNA transferred Resident #C with only 1 assist when the resident was supposed to be a 2 assist per the CNA info sheet. She further indicated a "teachable moment" was done for this CNA since she has had no other issues, but if any other incidents of this nature happen with any staff, the staff member will be written up. She has done several inservices which discuss giving care as indicated and following CNA sheets.</p> <p>3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;</p>						

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	<p>Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review and interview, the facility failed to assess a resident following a breathing treatment for 1 of 1 residents observed for breathing treatment administration of the 8 residents observed during medication pass observations. (Resident #D)</p> <p>Findings include:</p> <p>During a medication pass observation on 1/2/15 at 12:50 p.m., RN #2 washed her hands, observed the resident's respirations, radial pulse, and oxygen saturation level. RN #2 then administered the breathing treatment as ordered. When the treatment was completed, RN #2 cleaned and replaced the equipment and left the room. No follow up assessment of the resident was done.</p> <p>The record for Resident #D was reviewed on 1/2/15 at 1:30 p.m. Diagnoses included, but were not limited to, pulmonary insufficiency, asthma and dementia.</p> <p>The resident's Physician Order Summary</p>	F000328	<p><b>F328 -</b></p> <p>1) Nurse resigned prior to education.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice.</p> <p>3) Nurse's were in-serviced on performing assessments when administering Nebulizers. Nurses will be observed for proper assessment when administering Nebulizers.</p> <p>4) An audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting.</p> <p>5) January 24, 2015</p>	01/24/2015

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	<p>dated 1/1/15 indicated DuoNeb (medication for a breathing treatment) 0/-2.5 mg(milligrams)/3 ML (Milliliters) Solution Inhalation every six hours, 1 unit solution inhalation.</p> <p>The Medication Administration Record (MAR) for January 2015 indicated pulse, respirations and oxygen saturation levels were documented one time on the MAR when DuoNeb breathing treatments were given.</p> <p>Review of the care plan for alteration in respiratory status dated 3/22/12, indicated interventions to observe vital signs and respiratory status. Notify MD if needed for changes.</p> <p>Interview with LPN #2 on 1/3/15 at 5:07 a.m., indicated she would have checked the resident's vital signs (pulse, respiration and oxygen saturation level) prior to giving a nebulizer treatment. She further indicated she would have stayed with the resident during the treatment and then rechecked the pulse, respiration, and the oxygen saturation level after the breathing treatment.</p> <p>On 1/3/15 at 5:26 a.m. during an interview with RN #3, indicated she would have checked vital signs prior to a</p>			

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F000364 SS=E	<p>nebulizer treatment and again after the treatment. She further indicated she would have stayed with the resident while the treatment was running. The facility policy titled "Specific Medication Administration Procedures, Oral Inhalation Administration" was received by The DON (Director of Nursing) on 1/5/15 at 8:36 a.m. This current policy indicated "...Nebulizer...T. Obtain post-treatment pulse, respiratory rate and lung sounds and document findings...."</p> <p>3.1-47(a)(6)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview the facility failed to provide a resident with food served at the proper temperatures for 1 of 2 room trays observed. This had the potential to affect 10 resident who receive dinner room trays on the South Unit. (Resident #E)</p> <p>Findings include:</p>	F000364	<p><b>F364 -</b></p> <p>1) Resident #E was provided a new tray for dinner.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice.</p> <p>3) Nurse's and CNA's were in-serviced on passing room trays timely. Audit tool will be</p>	01/24/2015

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F000371 SS=E	<p>Observation on 1/5/15 at 6:30 p.m., Resident #E's room tray were obtained by Dietary Aide #1. The following was observed: french fries were 84.9 degrees Fahrenheit, the hot beef and cheddar was 94.3 degrees Fahrenheit and the french onion soup was 105 degrees Fahrenheit.</p> <p>Interview with Dietary Aide #1 on 1/5/15 at 6:42 p.m., indicated food should be served at 140 degrees Fahrenheit.</p> <p>Interview with the Dietary Manager on 1/5/15 at 7:00 p.m., indicated room trays went onto the South Unit at 5:45 p.m. She further indicated there was not a policy that indicated what the temperatures of the food should be on a room tray. She indicated 120 degrees Fahrenheit is considered safe for food.</p> <p>3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to distribute food under sanitary conditions</p>	F000371	<p>completed for room trays. Random temperature checks will occur at the time of delivery to resident rooms. 4) An audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5) January 24, 2015</p> <p><b>F371</b> - 1) Drinks are being covered when transported in the hallway. 2) All residents have the potential to be affected by the</p>	01/24/2015			

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	<p>related to fluids uncovered during meal passes for the South and ACU unit room trays. (South and ACU units)</p> <p>Findings include:</p> <p>1. During an observation of lunch service on 12/29/14 at 12:00 p.m. on the South Unit, RN #1 poured a cup of coffee from a carafe on a cart outside the nurses' station and carried it uncovered down the hallway to Room 222-2.</p> <p>At 12:03 p.m., CNA #1 poured 2 cups of coffee from a carafe on a cart outside the nurses' station, placed them on a lunch tray from the tray cart, and carried the tray with the uncovered drinks down the hallway to Room 204.</p> <p>During interviews with RN# 1 and CNA #1 following the observation, both indicated the beverage cart would normally be pulled right outside the resident rooms to serve the coffee. RN #1 and CNA #1 both further indicated the drinks should be covered if being carried down the hallway.</p> <p>2. On 12/29/14 during the ACU Unit dining room observation from 11:33 a.m. until 11:50 a.m., the ADON (Assist Director of Nursing) was observed to have carried a room tray from the Boutique dining room down the hallway</p>		<p>alleged deficient practice. 3) Nurse's, CNA's, and dietary staff were in-serviced on the proper way to transport food and fluids in the hallways. Audit tool will be completed to ensure food and drinks are being covered. 4) An audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5) January 24, 2015</p>	

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F000441 SS=D	<p>to Room #116 with 3 uncovered beverages.</p> <p>Interview with the ADON at 11:43 a.m. that same day, indicated she did not know why the beverages were uncovered on the room tray. She further indicated the beverages should have been covered while being transported down the hallway.</p> <p>3. On 1/5/15 at 6:19 p.m., CNA #2 was observed to have carried a room tray from the South Unit's nurses station area down the hallway to Room #204 with 2 cups of coffee uncovered.</p> <p>The facility policy titled "Nursing Responsibilities at Meal Service" was received by the Administrator on 12/31/14 at 8:15 a.m. and indicated was current. This policy indicated "...Distribution...All food must remain covered or in an enclosed cart while being distributed through the hallways...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to</p>			

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	<p>provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to maintain proper infection control related to the storage of resident's bedpans and a urine collection device for 3 of 35 resident whose rooms were observed. (ACU Unit and South Unit)</p>	F000441	<p><b>F441 -</b></p> <p>1) Items were removed from bathrooms and disposed of properly.</p> <p>2) All residents have the potential</p>	01/24/2015

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
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F000465 SS=E	<p>Findings include:</p> <p>During the Environmental tour on 1/5/15 from 10:50 a.m. until 11:30 a.m., with the Maintenance Director, DON (director of Nursing), and the Supervisor of Housekeeping and Laundry, the following was observed:</p> <p>a. Room 108 had a urine collection device on the bathroom floor, uncovered. Four residents shared this bathroom.</p> <p>b. Room 217 had a bedpan on the bathroom floor, uncovered. Four residents shared this bathroom.</p> <p>c. Room 204 had a bedpan on the bathroom floor, uncovered. Three residents shared this bathroom.</p> <p>Interview with the DON (Director of Nursing) after the tour indicated the bedpans and urine collection device should not have been on the bathroom floor uncovered.</p> <p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,</p>		<p>to be affected by the alleged deficient practice.</p> <p>3) Nurse's and CNA's were in-serviced on proper storage of bed pans, urinal, and urine collection devices. Environmental audit rounds are being completed to ensure proper placement of bed pans, urinal, and urine collection devices.</p> <p>4) An audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting.</p> <p>5) January 24, 2015</p>	

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	<p>sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred walls, brown substances on bathroom pull cords, and protruding and missing bathroom wall tiles on 3 of 3 units throughout the facility. (South Unit, Medicare Unit and ACU Unit)</p> <p>Findings include:</p> <p>During the Environmental tour on 1/5/15 from 10:50 a.m. until 11:30 a.m., with the Maintenance Director, DON (Director of Nursing), and the Supervisor of Housekeeping and Laundry, the following was observed:</p> <p>1. ACU Unit</p> <p>a. Room 114's bathroom pull cord had a brown substance on the cord. There were three residents who shared this bathroom.</p> <p>b. Room 115's bathroom pull cord had a brown substance on the cord. There were four residents who shared this bathroom.</p> <p>c. Room 116's bathroom pull cord had a brown substance on the cord. There were two resident who shared this bathroom.</p>	F000465	<p><b>F465</b> - 1) All room cords were replaced, and placed on a cleaning schedule. A new dresser was ordered. A drain was ordered and replaced. The tile in bathrooms were scheduled to be replaced by a contractor. The marred walls and base are being assessed and will be repaired/cleaned as needed. 2) All residents have the potential to be affected by the alleged deficient practice. An audit was conducted in the facility. Dressers and drains have been placed on order. 3) Staff were in-serviced on reporting changes in room condition by using Building Engines. Preventative Maintenance audit tool will be used to audit rooms. 4) The audit tool will be completed by the Maintenance Supervisor/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5) January 24, 2015</p>	01/24/2015			

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	<p>2. Medicare Unit</p> <p>a. Room 120's bathroom pull cord had a brown substance on the cord. There were two residents who shared this bathroom. The vanity light in the resident's room had a brown discolorization. There was one resident who resided in this room.</p> <p>b. In room 122 the drain in the sink peeled away on the edges. There was one resident who resided in this room.</p> <p>3. South Unit</p> <p>a. Room 201's bathroom pull cord had a brown substance on the cord. There were three residents who shared this bathroom. The baseboard by bed 1 had a brown substance on it and the wall next to the bathroom had black mars. There were two residents who resided in this room.</p> <p>b. Room 204's bathroom pull cord had a brown substance on the cord. There were three residents who shared this bathroom.</p> <p>c. Room 211's bathroom pull cord had a brown substance on the cord. There were four residents who shared this bathroom.</p> <p>d. Room 212's bathroom pull cord had a brown substance on the cord. There were</p>			

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	<p>four resident who shared this bathroom.</p> <p>e. Room 217's bathroom pull cord had a brown substance on the cord. There were four residents who shared this bathroom.</p> <p>f. In room 221, bed 1, the the bedside dresser was chipped and peeled.</p> <p>g. Room 222's vanity cord had a brown discoloration, the wall and the corner between the bathroom and the sink was marred. There were two residents who resided in this room.</p> <p>h. Room 223's bathroom wall tile was protruding, the bathroom pull cord and the vanity pull cords had a brown substance on them. There were two residents who resided in this room.</p> <p>i. Room 224's bathroom pull cord had a brown substance on the cord. There were two residents who resided in this room.</p> <p>j. Room 225 had missing wall tiles in the bathroom. There was one resident who resided in this room.</p> <p>k. Room 226's bathroom pull cord had a brown substance on the cord. There was one resident who resided in this room.</p> <p>Interview with the Maintenance Director,</p>			

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	DON and Supervisor of Housekeeping and Laundry, indicated all of the above were in need of cleaning and/or repair.  3.1-19(f)				