

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/29/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219		
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F0000	<p>This visit was for Investigation of Complaints IN00101349 and IN00101468.</p> <p>Complaint IN00101468 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00101349 - Substantiated. Federal/state deficiencies related to the allegations are cited at F514.</p> <p>Survey dates: December 27, 28, & 29, 2011</p> <p>Facility number: 000031 Provider number: 155076 AIM number: 100266150</p> <p>Survey team: Courtney Hamilton, RN TC Christi Davidson, RN</p> <p>Census bed type: SNF/NF: 119 Total: 119</p> <p>Census payor type: Medicare: 16 Medicaid: 88 Other: 15 Total: 119</p>	F0000			

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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F0514 SS=D	<p>Sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 1/3/12 by Jennie Bartelt, RN.</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure complete documentation of the comprehensive care plan upon admission to the facility for 1 of 5 residents reviewed for documentation of care plans in a sample of 5. (Resident C)</p> <p>Findings include:</p>	F0514	<p>F514</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident C no longer resides at Golden Living Center Brookview.</p>	01/16/2012	

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	<p>Resident C's record was reviewed on 12/28/2011 at 9:20 A.M. Diagnoses included, but were not limited to, cerebrovascular accident (stroke or CVA), left hemiplegia (paralysis), dysphagia (difficulty swallowing), diabetes, vertigo, and hypertension. The record indicated Resident C was admitted to the facility on 12/07/2011.</p> <p>A Nursing Admission Assessment, dated 12/07/2011, indicated the resident was experiencing pain in her back, had a Foley catheter, a gastrostomy tube (feeding tube org-tube), multiple bruises and reddened areas on her body, was unable to ambulate or transfer independently, had unstable diabetes, a history of diarrhea, vomiting, and vertigo (dizziness). Resident C was also admitted with Clostridium difficile (C-diff) infection and was to be placed in contact isolation. The resident was receiving hydrocodone (narcotic pain medication), Ritalin (stimulant), Lovenox injections (anticoagulant), and Trazadone (sleep aide).</p> <p>A current care plan, dated 12/07/2011, and titled "Immediate Plan of Care at Risk for Falls" indicated Resident C had a history of "...dizziness...2. Assist with mobility. Specify type of assistance..." Line left blank. "4. Assist with mobility. Specify type of assistance needed:...."</p>		<p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>During the survey on 12/28/2011, nursing administration reviewed all resident charts that had been there for less than 21 days and completed those care plans as applicable. The Nursing Administration team member reviews the chart of a new admit or re-admit within the 24 hours. The care plan is completed during the review.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Nursing Administration have all been trained to ensure the care plan is completed within the first 24 hours of admission. The new or readmission chart is reviewed by the Unit Manager/designee. DNS/designee will check results of the audits Monday through Friday during clinical start-up meeting.</p> <p>These corrective actions will</p>		

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	<p>Line left blank.</p> <p>A current care plan, dated 12/07/2011, titled "Immediate Plan of Care at Risk for..." Line left blank. "Problem: skin breakdown r/t [related to] incontinyency and imobility [sic]...."</p> <p>A current care plan dated 12/12/2011 titled, "Immediate Plan of Care at Risk for..." Line left blank. "Problem: Swallowing difficulty as related to Stroke. Use of supplemental tube feeding...."</p> <p>The record lacked documentation of the following care plans for Resident C: left hemiplegia, Lovenox injections, C-diff, Foley catheter, care and management of g-tube, diabetes, history of CVA, Ritalin, Trazadone, diarrhea and vomiting, or pain management and the need for hydrocodone.</p> <p>An interview with the DON on 12/28/2011 at 4:00 P.M., indicated the care plans provided were the only ones available.</p> <p>An interview with the Unit Manager on 12/28/2011 at 2:40 P.M., indicated there were no other care plans available. She indicated the admitting nurse was to do a immediate care plan on admission and then the care plans are updated following</p>		<p>be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS / designee will discuss any and all concerns regarding the development of the care plan and will report monthly to the QA&A.</p> <p>All corrections will be in place on January 16, 2012 We would like to ask for a desk review.</p>	

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	<p>the first care plan meeting 21 days following the resident's admission. She indicated the care plans can be updated before the care plan meeting as needed.</p> <p>A current facility policy provided by the Nurse Consultant on 12/29/2011 at 9 A.M., titled "Clinical Health Status/Change of Condition Guideline" dated January 2011 indicated "...the Immediate Plan of Care is completed within 24 hours of admission...."</p> <p>This federal tag relates to Complaint IN00101349.</p> <p>3.1-50(a)(1) 3.1-50(f)(3)</p>				