

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/13/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 I ST LA PORTE, IN 46350
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 9, 10, 11, 12 and 13, 2016</p> <p>Facility number: 000023 Provider number: 155062 AIM number: 100289400</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor type: Medicare: 5 Medicaid: 49 Private: 2 Other: 1 Total: 57</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 5/16/16.</p>	F 0000		

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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F 0314 SS=D Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview the facility failed to ensure a resident who entered the facility with a pressure ulcer received the necessary treatment and services to promote healing related to obtaining a treatment order and continued assessments for 1 of 3 residents reviewed for pressure ulcers of the 4 residents who met the criteria for pressure ulcers. (Resident #24)</p> <p>Finding includes:</p> <p>The closed record for Resident #24 was reviewed on 5/11/16 at 2:36 p.m. The resident was admitted to the facility on 3/3/16 and discharged to home on 4/7/16.</p>	F 0314	<p>1.The facility was unable to correct the deficient practice for resident #24 as he was discharged tohome on 4/7/2016. All residents had the potential to be adversely affected by the identified deficient practice</p> <p>2.A facility wide audit was conducted per theAssistant Director of Nursing (ADNS) and the Director of Nursing (DNS) toidentify any other residents with skin issues to ensure that on-goingmonitoring was being completed weekly with no other deficient practices noted.</p> <p>3.LicensedNursing staff to be re-inserviced per the Director of Clinical Education (DCE) relatedto skin assessment procedures including on-going</p>	06/10/2016

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	<p>The resident's diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, and left artificial hip joint.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 3/10/16 indicated the resident was not alert and oriented and was severely impaired for decision making. The resident was coded as not having any pressure ulcers.</p> <p>The Admission assessment form dated 3/3/16 indicated the resident was admitted to the facility with a red non-blanching area over the spine to mid back. The area measured 5 centimeters (cm) by 3.2 cm by 0 cm. There was no further documentation or assessment of the area.</p> <p>Physician Orders dated 3/3/16 indicated there were no treatment orders obtained for the non-blanching area.</p> <p>A wound evaluation sheet dated 3/13/16 indicated the resident had an open lesion to his mid spine. The area measured 4 cm by 4 cm by 0.1 cm. The open lesion was dark pink in color as well as the surrounding tissue. The wound status indicated the area was a soft scab surrounded by a dark pink area over bony prominence. There were no other</p>		<p>monitoring of identified alterations in skin integrity and completion of the Wound Evaluation Flow Sheet (see attachments, "Wound Evaluation Flow Sheet" and "Skin Assessment Guidelines"). All skin assessment schedules were placed in the electronic medical record (ETAR) to alert nursing staff when a resident is due for a wound assessment. DNS or designee to review all newly identified areas daily with Clinical Start-up to ensure a "Wound Evaluation Flow Sheet" was initiated. Also an RN was trained per the DNS and will be responsible for on-going weekly wound assessments and completion of the Wound Evaluation Flow records.</p> <p>4. The Wound RN will meet with the DNS weekly for facility wide wound rounds. DNS or designee will review all wound assessment documentation weekly to ensure that accurate and timely completion of all wound assessments was completed x 3 months. If any deficient practices are identified the DNS or designee will provide additional in-servicing for the identified nurse. If no deficient practices are identified after 3 months the DNS will review documentation monthly. DNS to present findings of rounds/reviews monthly to the Quality Assessment Process</p>		

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	<p>measurements or assessments of the area prior to 3/13/16. Continued review of the wound evaluation sheet indicated there were no further measurements or assessments of the open lesion after 3/13/16.</p> <p>Physician Orders dated 3/13/16 indicated the treatment of Bacitracin (an antibiotic ointment) to be applied to the mid spine topically one time a day until 3/24/16. Cover the area with a Mepore (a protective covering) dressing.</p> <p>Interview with the Director of Nursing (DON) on 5/12/16 at 2:45 p.m., indicated the resident had been admitted to the facility with a Stage 1 pressure ulcer. The assessment of the area and treatment should have been obtained at the time of the admission. The DON indicated the facility's policy was to measure pressure ulcers weekly until they were healed. She indicated after the area became a scab, a treatment was obtained, however it was not measured or assessed again after 3/13/16. She indicated she had spoken to the nurse who remembered the resident and the nurse indicated the area was healed by the time the resident was discharged on 4/7/16.</p> <p>The current 2014 Skin Integrity Guideline policy provided by the DON</p>				<p>Improvement (QAPI) committee. The QAPI committee to review for any trends or patterns of deficient practices (3 deficient practices in 1 month will be considered a trend/pattern) and will make further recommendations as necessary.</p>		

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F 0371 SS=D Bldg. 00	<p>on 5/13/16 at 8:00 a.m., indicated "A Licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the weekly skin review. A Licensed nurse to document weekly on identified wounds using the Wound Evaluation Flow Sheet."</p> <p>3.1-40(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, record review, and interview, the facility failed to store and prepare food under sanitary conditions related to stacked wet cups, dirty transportation carts, greasy oven shelving, crumbs on shelving, discolored caulking around the hand washing sink, a black substance on the wall behind the metal hand washing sink, dried brown substances along the wall, stained and peeling ceiling tiles, and rusted ceiling supports for 1 of 1 kitchens observed. (The Main Kitchen)</p> <p>Findings include:</p>	F 0371	<p>1 a) All black transportation carts are to be washed and sanitized after each meal All dietary staff will be re-inservice according to this standard by June 3, 2016 A weekly check of carts will be made and documented by the dietary manager for a 9 month period b & c) All dietary staff will be re-inservice on the daily and weekly cleaning schedule by June 3, 2016. These lists will be signed and dated upon completion The dietary manager will review lists and adherence to the cleaning schedule weekly for a 9 month period 2 All dietary staff will be re-inservice on</p>	06/03/2016

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	<p>1. During the Brief Kitchen Sanitation tour on 5/9/16 at 9:05 a.m., the following was observed:</p> <p>a. There were three black transportation carts observed with dried food spillage and crumbs.</p> <p>b. The metal shelf over the oven was greasy and there was an accumulation of dust.</p> <p>c. The metal shelf along the wall had an accumulation of crumbs.</p> <p>2. On 5/11/16 at 10:45 a.m., Dietary Aide #1 was observed in the main dining room. She had a cart of clean dishes which she stated came from the kitchen downstairs. There were two trays of 6 ounce plastic cups stacked on top of each other. The inside of the cups were wet. The Dietary Aide passed the cups to each table and turned them upside down. There were 36 plastic cups observed wet.</p> <p>Interview with the Dietary Aide on 5/11/16 at 10:54 a.m., indicated she was new to the facility and when the dishes came out of the dishwashing machine they were stacked like that on top of each other.</p>		current sanitation policy by June 3, 2016 The dietary manager will review the adherence to the policy on a weekly basis for a 9 month period	

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	<p>Interview with the Dietary Food Manager on 5/12/16 at 10:15 a.m., indicated the Dietary Aide had stacked the cups downstairs before bringing them up to the dining room. She further indicated when the cups come out of the dishwashing machine, they are not stacked, but because there is not enough time to allow the cups to air dry between breakfast and lunch, they were not fully dry on the inside.</p> <p>Review of the current Sanitation policy provided by the Dietary Food Manager indicated all items should be completely free of moisture and glasses should be stored un-stacked.</p> <p>On 5/13/16 at 9:20 a.m., interview with the Dietary Manager indicated all of the above was in need of cleaning and/or repair.</p> <p>3.1-21(i)(3)</p>			

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F 0431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and</p>	F 0431	1. The identified bottle of	06/10/2016

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	<p>interview, the facility failed to ensure medications were discarded according to manufacturer's guidelines related to an Exelon patch (a medicated patch used to increase memory function) for 1 of 10 residents observed during medication pass. The facility also failed to discard expired multi dose vials of Tuberculin after the date opened for 1 of 4 wings. (Resident #4 and B Wing).</p> <p>Findings include:</p> <p>1. On 5/10/16 at 10:24 a.m., the B Wing medication refrigerator was observed. Inside the refrigerator there was one multi dose vial of Tuberculin with an open date of 3/9/16.</p> <p>The current 5/2012 Medication Storage in the Facility policy received from the Director of Nursing (DON) on 5/10/12 at 1:35 p.m., indicated "When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The expiration date of the vial or container will be 30 days unless the manufacture recommends another date or regulations/guidelines required different dating. Tubersol (Tuberculin PPD) do not use more than 30 days."</p> <p>Interview with the DON on 5/10/16 at 1:40 p.m., indicated the multi dose vial of</p>		<p>Tuberculin was immediately destroyed per facility policy per the Licensed Nurse. LPN #1 was immediately inserviced per the DNS on proper disposal of Exelon patches. 2. A complete facility audit of all medication storage areas was completed per the DNS and ADNs with no other deficient practices identified. 3. Licensed Nurses are to be re-inserviced per the Pharmacy Consultant on the policy and procedure for medication storage and disposal of medicated patches (see attached "Medication Storage in the Facility") and the procedure for completion of the "Medication Storage Audit (see attached "Medication Storage Audit Form"). The 11-7 shift licensed nurse on each unit is to perform a medication cart and medication refrigerator audit daily, utilizing the Medication Storage Audit form. If expired medications or incorrectly labeled medications are identified they are to be immediately removed per the licensed nurse and destroyed/disposed of per facility policy and re-ordered immediately as needed. The DNS, ADNS and DCE (or their designee) are each assigned to a medication cart and refrigerator for completion of a Medication storage audit 2x/week utilizing the Medication Storage Audit form x 3 months if no deficient practices are identified further audits will be</p>		

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	<p>Tuberculin should have been discarded after 30 days.</p> <p>2. On 5/12/2016 at 8:38 a.m., LPN #1 was observed preparing and pouring medication for Resident #4. At that time, the LPN pulled out an Exelon Patch from the drawer. She removed the patch from the wrapper and threw the wrapper away in the garbage can on the side of the medication cart. She wrote the date and her initials on the patch and proceeded into the resident's room with oral medications and the patch. The LPN removed the old patch from the resident's back and administered the new patch to a different site. At that time, she placed the old patch in the plastic med cup and then threw everything into the garbage can on the side of the cart.</p> <p>Interview with LPN #1 on 5/12/16 at 9:15 a.m., indicated she had always thrown the Exelon patch in the garbage can on the side of the cart. She was unaware of any specific instructions for disposal.</p> <p>Interview with the DON on 5/12/16 at 10:40 a.m., indicated she had spoken to the Pharmacist who indicated the patch should be disposed of according to the manufacturer's recommendations.</p>		<p>done monthly and on-going. The DCE or designee is to audit medicationpatch disposal on all 3 shifts with 10% of nurses being completed weekly x 4weeks then 10% monthly until 100% compliance has been reached and maintainedfor 3 consecutive months. 4. The DCE or designee will report the results of the audits monthly to the Quality Assessment Process Improvement (QAPI)committee. The QAPI committee to review for any trends or patterns of deficient practices (3 deficient practices in 1 month will be considered a trend/pattern) and make further recommendations as necessary.</p>				

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F 0465 SS=D Bldg. 00	<p>The medication manufacturer's website, www.exelonpatch.com, was reviewed on 5/12/16 at 11:24 a.m. The patient instructions indicated "Throw away the used Exelon Patch. Fold the used Exelon Patch in half (with the sticky sides together) and put it back into the pouch that you saved and throw away in the garbage can."</p> <p>3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, 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 displaced cove bases, peeling/chipped paint, a missing thermostat cover, marred walls, peeling non-skid floor strips, holes in the ceiling tiles, and discolored caulking for 3 of 3 halls. (A, B, and D Halls)</p> <p>Findings include:</p> <p>1. During the Brief Kitchen Sanitation tour on 5/9/16 at 9:05 a.m., the ceiling tiles were observed to be stained and peeling and the metal supports surrounding the tiles were rusted.</p>	F 0465	<p>1 the kitchen ceiling metal supports will be scraped and repainted and the ceiling tiles will be replaced 2a the caulking around the hand washing sink was removed and recaulked b the wall behind the metal hand washing sink will be cleaned, sanitization and repaired 3a thermostat cover was replaced the wall behind the head of each bed will be repaired and the non-skid strips will be replaced b the paint underneath the paper towel holder in the bathroom was scraped and repainted the caulking around the toilet base was removed and replaced c the paint was scraped in the bathroom door frame the cove base was replaced the ceiling</p>	06/03/2016			

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	<p>2. On 5/13/16 at 9:20 a.m., during the Full Kitchen Sanitation Tour, the following was observed:</p> <p>a. The white caulking around the hand washing sink near the entrance of the kitchen was discolored.</p> <p>b. There was a black substance along the wall behind the metal hand washing sink.</p> <p>Interview with the Dietary Manager at the time indicated all of the above was in need of cleaning and/or repair.</p> <p>3. During the Environmental Tour on 5/13/16 at 9:44 a.m. with the Maintenance Supervisor, the following was observed:</p> <p>a. A Hall</p> <p>1. Room 13: The thermostat cover was missing from the wall. One resident resided in this room.</p> <p>2. Room 17: The wall behind the head of each bed was marred and the non-skid strips on the floor were peeling. Two residents resided in this room.</p> <p>b. B Hall</p>		<p>tiles were replaced in the bathroom cove basing The maintenance director will complete environment checks weekly to monitor needs of the facility for repair, painting and replacement for a 12 month period</p>				

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	<p>1. Room 29: The paint underneath the paper towel holder in the bathroom was chipped and peeling. Three residents shared this bathroom.</p> <p>2. Room 35: The white caulking around the base of the toilet was discolored. Three residents shared this bathroom.</p> <p>c. D Hall</p> <p>1. Room 1: The cove bases were peeling from the bathroom wall. The paint along the bottom edge of the bathroom door frame was chipped and peeling. Two residents resided in this room and used this bathroom</p> <p>2. Room 26: There were multiple holes in the ceiling tile. The cove base was peeling from the bathroom wall. Two residents shared this room and bathroom.</p> <p>Interview with the Maintenance Supervisor at the time of the tour, indicated the above areas were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/13/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LAPORTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 I ST LA PORTE, IN 46350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	