

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/24/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00185590, IN00185577, IN00186590, IN00186886, IN00185542 and IN00187266.</p> <p>Complaint IN00185590 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00185577 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00186590- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00186886- Substantiated. Federal/State deficiencies related to the allegations are cited at F282.</p> <p>Complaint IN00185542- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00187266- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F314.</p> <p>Survey dates: November 12, 13, 16, 18, 19, 20, 23 and 24, 2015</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 0157 SS=D Bldg. 00	<p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 2 Medicaid: 66 Other: 14 Total: 82</p> <p>Sample:12</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on December 3, 2015.</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</p>			

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	<p>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).</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 follow their wound protocol for timely notification of physician and family of a pressure wound for 1 of 3 residents reviewed for pressure ulcers in a sample of 12. (Resident E)</p> <p>Finding includes:</p>	F 0157	<p>Corrective action for Resident E was accomplished by physician notification, obtaining treatment order, completing wound assessment and treatment.</p> <p>Daughter, Renee, was in the facility aware of shearing/pressure ulcer and notified of new orders. All residents have the potential to be affected by the deficient practice.</p>	12/24/2015

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	<p>On 11/23/15 at 2:00 P.M., the clinical record for Resident E was reviewed. Resident E was admitted to the facility on 11/7/13. The diagnoses included, but not limited to, other cerebrovascular disease, dysphagia unspecified, encounter for attention to gastrostomy and aphasia following unspecified cerebrovascular disease.</p> <p>A nursing progress note, dated 11/17/15 at 18:16 (6:18 P.M.), indicated "...Type: SBAR [Situation, Background, Assessment, Recommendation] - Change in Condition...Situation: Called to resident room by family member asking about a dressing that was on the right posterior thigh and area that is on the buttock...Assessment: skin is macerated on right posterior thigh some green drainage noted. no s/sx [signs and symptoms] of distress noted...Response: [name of physician] notified order received and [name of daughter] present at facility and aware of order received...."</p> <p>A Wound Evaluation Flow Sheet, provided by the Director of Nurses (DON) on 11/23/15 at 3:30 P.M., indicated, "...Date: 11/17/15...Stage Type: 2 [sic]...Measurements: L [length] 7.4 W [width] 4.0 D [depth] 0.1...Exudate: Color:0... Amount: scant...Pain: 0... If infection or</p>		<p>All residents were assessed for skin breakdown on 11/17/15. No additional residents were identified to have new, alteration in skin integrity. All residents requiring MaxiLift transfers were assessed for appropriate sling size. Sling sizes were added to the Resident Care Guide. All care plans were reviewed. All residents identified as being at risk to develop pressure ulcers have appropriate care plan in place. Licensed nurses were educated on but not limited to wound policy/procedure, MaxiLift transfers, appropriate sling size for MaxiLift transfers, , certified nursing assistant use of Stop and Watch form to notify licensed nurse of any new alteration in skin integrity. Certified nursing assistants were educated on but not limited to MaxiLift transfers, appropriate sling size for MaxiLift transfers, use of Stop and Watch form to notify licensed nurse of any new alteration in skin integrity. Certified nursing assistants will complete a Stop and Watch form to notify the licensed nurse of any new, alteration in skin integrity. Licensed nurse will assess wound, complete wound assessment, notify physician, obtain treatment order, notify resident and, if known, responsible party. Licensed nurse will notify the Director of Nursing of new alteration in skin integrity. Licensed nurse will</p>	

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	<p>colonization present, describe: Epithelial...Wound Margins; intact... Current Treatment: Cleanse, Zinc, Tegaderm Foam...Pressure Redistribution Mattress...."</p> <p>On 11/24/15 at 9:30 A.M., an interview was conducted with Resident E's daughter. The daughter indicated she came to visit her mother on 11/17/15, and noticed she had a dressing on her thigh. She indicated she pulled off the dressing, which she described as round, and found a large area which she described as a pressure ulcer underneath the dressing. She was told by a CNA (Certified Nursing Assistant) that it was reported previously to a nurse but the nurse didn't do anything about it. The daughter further indicated she was upset she had not been notified and reported it to the head of nursing.</p> <p>On 11/24/15 at 10:05 A.M., an interview was conducted with CNA #1. CNA #1 indicated she was caring for Resident E sometime around November 9th because she was giving Resident E a complete bed bath with another CNA and noticed an area on her right thigh. CNA #1 indicated she notified the nurse of the area and asked her to come look at it. CNA#1 further indicated a couple of weeks went by and she inquired again</p>		<p>initiate an appropriate care plan. Licensed nurse will complete weekly skin assessment. Unit Manager or designee will complete weekly wound assessment. Physician will be notified of changes in wound. Resident and, if known, responsible party will be notified of changes in wound and wound treatment. Nurse Manager will audit notification of physician, resident, and if known, responsible party, of new alteration of skin integrity 5xweek x 4 weeks; 3xweek x 4 weeks; 1xweek x 4 months. Results of these audits will be reviewed and discussed in Daily Clinical Startup Meeting and in monthly Quality Assurance Performance Improvement (QAPI) meeting through June 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>		

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	<p>with a nurse as to what was being done about Resident D's thigh because it had "yellowish stuff" coming out of it and the nurse then looked at her thigh and placed a dressing on it. CNA#1 indicated she did not always work that particular wing or with Resident E and that was why it was so long in between her reporting to the nurse.</p> <p>On 11/24/15 at 11:50 A.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated Resident E's daughter had inquired about her mother's thigh and it was investigated as a grievance. During the course of the investigation it was determined the nurse did not follow the wound protocol and notification of physician, daughter and treatment were delayed as a result. The Director of Nurses described the protocol that should have been followed and that was that the physician and family should have been notified right away.</p> <p>On 11/24/15 at 1:20 P.M., a Clinical Health Status-Change of Condition Guideline, with the effective date of 3/24/15, and provided by the Director of Nurses was reviewed. The Change of Condition Guideline indicated, "...Change of Condition-SBAR: The process for identification of change of condition includes gathering objective</p>			

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F 0282 SS=D Bldg. 00	<p>data and documenting assessment findings, resident/patient response, and physician and family notification. Communication both written and verbal, are integral part of actions needed for change of condition...Monitoring/Compliance: SBAR guide is used to communicate change of condition to physician...Documentation in the electronic record supports MD [Medical Doctor] / Family notification is completed timely."</p> <p>This Federal tag relates to Complaint IN00187266.</p> <p>3.1-5(a)(3)</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.</p>			
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	<p>Based on record review and interview, the facility failed to ensure a Resident's plan of care was followed related to the administration of Methotrexate (a medication used to treat autoimmune disorders). This deficient practice affected 1 of 3 residents reviewed for medication administration in a sample of 12. (Resident C)</p> <p>Finding includes:</p> <p>On 11/19/15 at 1:00 P.M., the clinical record for Resident C was reviewed. The diagnoses, included but were not limited to, lupus and diabetes mellitus.</p> <p>Resident C was hospitalized at (name of hospital) from 10/27/15 to 11/3/15. Resident C was readmitted to the facility on 11/3/15, with a physician's order that indicated she was to receive Methotrexate. The order indicated, "...Methotrexate [Methotrexate 2.5 mg (milligram) oral tablet] 8 Tab, By Mouth, Weekly on Friday, 20 MG...."</p> <p>The Medication Administration Record (MAR) indicated, "...Methotrexate Sodium Tablet 15 MG. Give 2 tablet by mouth at bedtime every Fri. related to Systemic Lupus Erythematosus [an autoimmune disorder] dosage 30 mg. Order date 11/3/15...." The MAR</p>	F 0282	<p>Corrective action for Resident C was accomplished by verifying physician orders and correcting dose of methotrexate. All residents have the potential to be affected by the deficient practice. All physician orders have been reviewed and verified. Licensed nurses will be educated on order transcription. Admission orders will be verified by a second licensed nurse upon admission and before orders are communicated to pharmacy. Unit Managers or designee will audit admission orders to ensure accuracy 5xweek x4weeks; 3xweekx4weeks; 1xweekx4months. Results of these audits will be reviewed and discussed in Daily Clinical Startup Meeting and in monthly Quality Assurance Performance Improvement (QAPI) meeting through June 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>	12/24/2015			

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	<p>indicated that on 11/6/15 at 2100 (9:00 P.M.), Resident C received a 30 mg dose of Methotrexate and not the ordered 20 MG.</p> <p>On 11/19/15 at 2:30 P.M., an interview was conducted with the Unit Manager of the C wing. The Unit Manager indicated that Resident C's order for Methotrexate was increased when the Resident was at the hospital and that she was aware that on 11/6/15, the MAR indicated 30 mg of Methotrexate was to be given. She further indicated the Methotrexate was dispensed in 2.5 mg tablets and she could not prove that Resident C did not receive the 30 mg dosage because she could not prove how many pills were in the bottle at the time of administration but that she had rewritten the order to reflect the 20 mg dosage and the amount of tablets needed to prevent further occurrences.</p> <p>On 11/19/15 at 3:30 P.M., the policy titled Medication Administration-Preparation and General Guidelines Section 7.2 Revised November 2011, was provided by the Director of Nurses. The policy indicated "...7.2 MEDICATION ADMINISTRATION-GENERAL GUIDELINES...Procedures...A. Preparation...5. Prior to administration, the medication and dosage schedule on</p>			

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F 0314 SS=D Bldg. 00	<p>the resident's medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. A "direction change, refer to chart" sticker may be used to indicate a change in directions...."</p> <p>This Federal tag relates to Complaint IN00186886.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on record review and interview, the facility failed to follow their wound</p>	F 0314	Corrective action for Resident E was accomplished by physician notification, obtaining treatment	12/24/2015	

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	<p>protocol for the timely physician notification and treatment of a pressure wound for 1 of 3 residents reviewed for pressure ulcers in a sample of 12. (Resident E)</p> <p>Finding includes:</p> <p>On 11/23/15 at 2:00 P.M., the clinical record for Resident E was reviewed. Resident E was admitted to the facility on 11/7/13. The diagnoses included, but not limited to, other cerebrovascular disease, dysphagia unspecified, encounter for attention to gastrostomy and aphasia following unspecified cerebrovascular disease.</p> <p>A nursing progress note, dated 11/17/15 at 18:16 (6:18 P.M.) indicated, "...Type: SBAR [Situation, Background, Assessment, Recommendation] - Change in Condition...Situation: Called to resident room by family member asking about a dressing that was on the right posterior thigh and area that is on the buttock...Assessment: skin is macerated on right posterior thigh some green drainage noted. no s/sx of distress noted...Response: [name of physician] notified order received and [name of daughter] present at facility and aware of order received...."</p>		<p>order, completing wound assessment and treatment. Daughter, Renee, was in the facility aware of shearing/pressure ulcer and notified of new orders. All residents have the potential to be affected by the deficient practice. All residents were assessed for skin breakdown on 11/17/15. No additional residents were identified to have new, alteration in skin integrity. All residents requiring MaxiLift transfers were assessed for appropriate sling size. Sling sizes were added to the Resident Care Guide. All care plans were reviewed. All residents identified as being at risk to develop pressure ulcers have appropriate care plan in place. Licensed nurses were educated on but not limited to wound policy/procedure, MaxiLift transfers, appropriate sling size for MaxiLift transfers, , certified nursing assistant use of Stop and Watch form to notify licensed nurse of any new alteration in skin integrity. Certified nursing assistants were educated on but not limited to MaxiLift transfers, appropriate sling size for MaxiLift transfers, use of Stop and Watch form to notify licensed nurse of any new alteration in skin integrity. Certified nursing assistants will complete a Stop and Watch form to notify the licensed nurse of any new, alteration in skin integrity. Licensed nurse will assess</p>	

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	<p>A Wound Evaluation Flow Sheet was provided by the Director of Nurses (DON) on 11/23/15 at 3:30 P.M. The Wound Evaluation Flow Sheet indicated, "...Date: 11/17/15...Stage Type: 2 [sic]...Measurements: L [length] 7.4 W [width] 4.0 D [depth] 0.1...Exudate: Color:0... Amount: scant...Pain: 0... If infection or colonization present, describe: Epithelial...Wound Margins; intact... Current Treatment: Cleanse, Zinc, Tegaderm Foam...Pressure Redistribution Mattress...."</p> <p>On 11/24/15 at 9:30 A.M., an interview was conducted with Resident E's daughter who indicated she came to visit her mother on 11/17/15, and noticed she had a dressing on her thigh. She indicated she pulled off the dressing, which she described as round, and found a large area which she described as a pressure ulcer underneath the dressing. She was told by a CNA (Certified Nursing Assistant) that it was reported previously to a nurse but the nurse didn't do anything about it. The daughter indicated she was upset she had not been notified and reported it to the head of nursing.</p> <p>On 11/24/15 at 10:05 A.M., an interview was conducted with CNA #1. CNA #1 indicated she was caring for Resident E sometime around November 9th because</p>		<p>wound, complete wound assessment, notify physician, obtain treatment order, notify resident and, if known, responsible party. Licensed nurse will notify the Director of Nursing of new alteration in skin integrity. Licensed nurse will initiate an appropriate care plan. Licensed nurse will complete weekly skin assessment. Unit Manager or designee will complete weekly wound assessment. Physician will be notified of changes in wound. Resident and, if known, responsible party will be notified of changes in wound and wound treatment. Nurse Manager will audit notification of physician, resident, and if known, responsible party, of new alteration of skin integrity 5xweek x 4 weeks; 3xweek x 4 weeks; 1xweek x 4 months. Results of these audits will be reviewed and discussed in Daily Clinical Startup Meeting and in monthly Quality Assurance Performance Improvement (QAPI) meeting through June 2016 or until deficient practice has been corrected. Plan will be revised as needed to ensure corrective action for this deficient practice has been accomplished.</p>	

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	<p>she was giving Resident E a complete bed bath with another CNA and noticed an area on her right thigh. CNA #1 indicated she notified the nurse of the area and asked her to come look at it. CNA#1 further indicated a couple of weeks went by and she inquired again with a nurse as to what was being done about Resident E's thigh because it had "yellowish stuff" coming out of it and the nurse then looked at her thigh and placed a dressing on it. CNA#1 indicated she did not always work that particular wing or with Resident E and that was why it was so long in between her reporting to the nurse.</p> <p>On 11/24/15 at 11:50 A.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated Resident E's daughter had inquired about her mother's thigh and it was investigated as a grievance. During the course of the investigation it was determined the nurse did not follow the wound protocol and notification of physician, daughter and treatment were delayed as a result. The Director of Nurses indicated when the CNA discovered the wound she should have initiated a STOP and WATCH sheet, that sheet, would have alerted the Unit Manager as well as herself that an area had been found and she could have initiated an investigation right away. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/24/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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	<p>Director of Nurses then described the protocol that should have been followed and that was that the physician and family should have been notified right away, a careplan initiated or updated and an internal incident report with investigation initiated.</p> <p>On 11/24/15 at 1:20 P.M., a Clinical Health Status-Change of Condition Guideline with the effective date of 3/24/15, was provided by the Director of Nurses. The Change of Condition Guideline indicated, "...Change of Condition-SBAR: The process for identification of change of condition includes gathering objective data and documenting assessment findings, resident/patient response, and physician and family notification. Communication both written and verbal, are integral part of actions needed for change of condition...Monitoring/Compliance: SBAR guide is used to communicate change of condition to physician...Documentation in the electronic record supports MD [Medical Doctor] / Family notification is completed timely.</p> <p>This Federal tag relates to Complaint IN00187266.</p> <p>3.1-40(a)(1)</p>			

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	3.1-40(a)(2)				