

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
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F0000	<p>This visit was for the investigation of Complaint IN00103853.</p> <p>Complaint IN00103853-Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F328.</p> <p>Survey dates: February 28, 29, and March 1, 2012</p> <p>Facility number: 000077 Provider number: 155157 AIM number: 100266490</p> <p>Survey team: Barbara Gray RN TC Leslie Parrett RN (February 28 and 29, 2012)</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 15 Medicaid: 70 Other: 5 Total: 90</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings</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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	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/4/12 Cathy Emswiller RN</p>			

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F0157 SS=D	<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 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 interview and record review, the facility failed to notify a resident's family of suspected deep tissue injury and treatment ordered, for 1 of 3 resident's reviewed for physician notification in the</p>	F0157	<u>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 the survey report.</u>	03/30/2012			

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	<p>sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 2/28/12 at 11:30 A.M. Diagnoses included but were not limited to bilateral below the knee amputation, insulin dependent diabetes, peripheral vascular disease, and pressure ulcer.</p> <p>A local hospital preadmission note for Resident #A dictated 12/19/11 at 9:18 A.M., indicated the following: Preoperative diagnosis: Bilateral lower extremity gangrene with left fifth toe osteomyelitis and ischemic rest pain of both lower extremities.</p> <p>A local hospital complete assessment for Resident #A dated 12/22/11 at 6:32 A.M., indicated the following: Resident #A had no pressure areas on admission. Resident #A's "bottom slightly reddened but no open areas noted".</p> <p>A local hospital complete assessment for Resident #A dated 12/24/11 at 12:09 P.M., indicated the following. Resident #A had a suspected deep tissue pressure area on his sacrum, with serosanguineous drainage. A photo was taken and Mepilex was applied to the pressure area.</p>		<p><u>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</u> Tag F157 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: All licensed Nursing staff have been in serviced on Notification of Change in resident health status. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Staff were in serviced on 3-01-12 licensed Nursing staff have been in serviced on Notification of Change in resident health status. New licensed nursing staff will have education on Notification of Change in resident health status. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing Staff were in serviced on 3-1-12 on Notification of Change in resident health status. New staff will have education on Notification of Change in resident health</p>		

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	<p>A readmission assessment for Resident #A dated 12/26/11, indicted the following: 6 Centimeter (cm) by 10 cm suspected deep tissue pressure area on coccyx.</p> <p>A wound evaluation flow sheet for Resident #A dated 12/26/11, indicated the following: 6 Cm long by 10 cm wide by superficial deep suspected deep tissue injury, with scant serous exudate. Wound bed was purplish in color, with wound margins intact, and surrounding skin slightly red. Treatment was Vasolex with Combiderm dressing, and was to be changed every 3 days.</p> <p>A physician's order for Resident #A dated 12/26/11, indicated the following order: Vasolex (Trypsin with Castor Oil and Peruvian Balsam) ointment external. Rinse decubitus ulcer on coccyx/buttock area with normal saline, then apply Vasolex ointment and cover with Combiderm dressing. Change every 3 days and as needed.</p> <p>No information could be located in Resident #A's record the family had been notified of the initial condition of Resident #A's wound or the initial treatment ordered upon readmission from the local hospital.</p>		<p>status. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED, DNS or designee will monitor 24 hour reports, nurses notes, concern forms, Clinical Start up, Care Management meetings and morning meetings for Notifications of Change in resident health status. This will be done 5 times's a week for 4 weeks then 3 times's a week for 4 weeks, then 1 time a week for 4 weeks Any patterns or trends will be reported to monthly QA meeting and appropriate action plans will be written and implemented. New licensed staff will have education on Notification of Change in resident health status.</p>				

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	<p>An interview with LPN #1 on 3/1/12 at 10:12 A.M., indicated no information could be located in Resident #A's record the family had been notified of the initial condition of Resident #A's wound or the initial treatment ordered upon readmission from the local hospital.</p> <p>The most recent Notification of Change in Resident Health Status procedure, provided by the Director of Nursing on 3/1/12 at 2:00 P.M., indicated the following: "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known the resident's legal representative or an interested family member when there is: (A) An accident which results in injury and has the potential for requiring physician intervention. Notification: 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 (i.e. deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications.)... (C) A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)"....</p>						

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	<p>This federal tag relates to Complaint IN00103853.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			

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F0328 SS=D	<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; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to provide a resident with foot care, resulting in long thick toenails, for 1 of 3 residents sampled for foot care in the sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 2/28/12 at 1:55 P.M. Resident #C was admitted to the facility on 1/13/12. Diagnoses included but were not limited to dementia, insulin dependent diabetes, and pressure ulcers on the right and left inner knee, coccyx, and a healed right heel.</p> <p>Resident #C's admission Minimum Data Set assessment dated 2/13/12, indicated the following: Resident #C required extensive assistance of 2 persons for bed mobility and transfer, and required</p>	F0328	<p>Tag F328 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident #C was seen by the podiatrist on 3-01-12. An audit of all residents was conducted on 3-2 thru 3-3-12 for nail care. Those residents who required nail care received it at the time of the audit with the exception of those who required the services provided by a podiatrist. Those residents who required the services provided by a podiatrist were seen on 3-00-12 by the podiatrist. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: An audit of all residents was conducted on 3-2 thru 3-3-12 for nail care. Those residents who required nail care relieved it at the time</p>	03/30/2012			

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	<p>extensive assistance of 1 person for personal hygiene.</p> <p>Resident #C's feet were observed on 3/1/12 at 9:16 A.M., with LPN #1. Resident #C's last 2 toenails of her left foot and all 4 toenails (except the great toe) on her right foot were long and thick. At that time LPN #1 indicated the facility staff could trim the toenails down "some", but Resident #C would need to see a podiatrist because her toenails were thick.</p> <p>An interview with RN #2 on 3/1/12 at 9:22 A.M., indicated Resident #C had not seen a podiatrist.</p> <p>An interview with the Social Service Designee (SSD) on 3/1/12 at 9:34 A.M., indicated the podiatry group was in the facility on 2/7/12, and missed providing care for some residents, and was informed they would return on 2/8/12. The SSD indicated Resident #C was not on the list to be seen on 2/7/12 but she had give the podiatry group her consent for podiatry services when they came in on 2/7/12, and they should have seen her. The SSD indicated she believed the podiatry group did not return on 2/8/12. The SSD indicated she called the podiatry group on 2/9/12, and requested they finish up, and was informed they could not provide care that day. The SSD indicated the podiatry</p>		<p>of the audit with the exception of those who required the services provided by a podiatrist. Those residents who required the services provided by a podiatrist were seen on 3-05-12 by the podiatrist. Nursing staff were in serviced on 3-14-12 Nails (finger and toe) care of and shower sheets. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing staff were in serviced on 3-12-12 Nails (finger and toe) care of and shower sheets. CNA's and nurses will be in serviced on utilization of a Resident shower sheet that is to be filled out after each shower. A nurse will review the sheet for any issues related to nail care. Residents who require nail care provided by a podiatrist will be referred to the SSD for scheduling of appointment. New staff will have education regarding resident shower sheet's and nail care during orientation. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: Unit managers or designee will monitor shower sheets for any</p>				

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	<p>group provided care for the residents at the facility approximately every 2 to 3 months.</p> <p>An interview with the Administrator on 3/1/12 at 12:50 P.M., indicated he notified the podiatry group and they informed him they were in the facility on 2/7/12 and finished up on 2/8/12. The Administrator indicated the podiatry group informed him that Resident #C was not in the building on 2/7/12 or 2/8/12.</p> <p>An interview with the SSD on 3/1/12 at 12:52 P.M., indicated she did not realize the podiatry group was in the facility on 2/8/12, because they usually came to her to discuss changes, go over the list, and get towels they needed.</p> <p>A fax from the podiatry group provided by the Administrator on 3/1/12 at 1:07 P.M., indicated the following: Attempted to see Resident #C on 2/7/12 and 2/8/12. She was out at a doctor's appointment on both visits.</p> <p>A review of Resident #C's record on 3/1/12 at 1:20 P.M., with LPN #1, indicated Resident #C had a wound care appointment on 2/7/12. No information was available Resident #C was out of the facility on 2/8/12. LPN #1 indicated Resident #C may not have been in her</p>		<p>issues related to nail care and follow up accordingly. This will be done 5 times's a week for 4 weeks then 3 times's a week for 4 weeks, then 1 time a week for 4 weeks. Any patterns or trends will be reported to monthly QA meeting and appropriate action plans will be written and implemented.</p>				

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	<p>room when the podiatry group was in the facility on 2/8/12.</p> <p>This federal tag relates to Complaint IN00103853.</p> <p>3.1-47(a)(7)</p>				