

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 04/05/2016
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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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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00195929.</p> <p>Complaint IN00195929 - Substantiated. Federal/State deficiencies related to the allegation were cited at F309 and F514.</p> <p>Survey date: April 5, 2016.</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census Payor type: Medicare: 05 Medicaid: 66 Other: 09 Total: 80</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	F000 - Preparation, submission and implementation of this plan of correction does not constitute an admission of 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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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received the necessary treatment and services related to the assessment and monitoring of high blood pressure for 1 of 3 residents reviewed for assessments with a change of condition in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 04/05/16 at 9:27 a.m. The resident's diagnoses included, but were not limited to diabetes mellitus, hypertension, and post shoulder surgery.</p> <p>The Admission Orders from the hospital discharge, dated 02/05/16, brought with the resident upon admission to the facility on 03/11/16, included metoprolol (anti-hypertensive) 25 mg XL (long</p>	F 0309	<p>F309 - 1) Resident #Bwas discharged from the facility prior to the survey. 2) All residents havethe potential to be affected by the alleged deficient practice. A record reviewof all residents that had a change of condition over the previous 30 days wascompleted. Noted concerns were addressed as needed. 3) In-service(re-education) for nurses on the completion of assessments as related to achange in condition was completed. An audit tool will be completed by theDNS/designee documenting that assessments are completed on all changes ofcondition. Audits will beconducted 7 times per week for 4 weeks, then 5x per week for 4 weeks, weeklyfor 4 weeks, and then monthly for 12 weeks. 4) Audit toolwill be reviewed monthly for 6 months in facility QAPI meeting to track andtrend for concerns. Finding no patterns,it will then be reviewed quarterly thereafter. Action Plans will be</p>	04/25/2016
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	<p>acting), one tablet daily. The resident was admitted from home and brought medications into the facility from home which included the metoprolol (anti-hypertensive) 25 mg XL.</p> <p>The Admission Nurses' Assessment, dated 03/11/16 at 11:54 a.m., indicated the resident's blood pressure was 179/98 (normal 100-140/60-90).</p> <p>There was no further assessment of the resident's blood pressure from 03/11/16 at 11:54 a.m. through 03/12/16 at 11:45 a.m. in the Nurses' Progress notes.</p> <p>The Medication Administration Record indicated the resident had not received the morning dose of metoprolol on 03/12/16.</p> <p>A Nurses' Note, dated 03/12/16 at 3:59 p.m., late entry for 11:45 a.m., indicated, "Res (resident) alert and orient. (oriented)...requested to have b/p (blood pressure) taken, upon entering room with b/p machine resident noted to be on phone. resident (sic) hung up phone and stated that she had called 911. residents (sic) b/p 212/100-70 (pulse). resident (sic) requested to go to hospital..."</p> <p>A Nurses' Note, dated 03/12/16 at 7:30 p.m., indicated the resident was</p>		developed for any identified concern. 5) April 25, 2016	

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	<p>transported to hospital earlier in the day and arrangements had been made to transfer to another facility after being discharged from the hospital due to being unhappy with the facility's smoking policy, .</p> <p>The Emergency Room Documentation, dated 03/12/16 at 12:56 p.m., indicated, "...arrived...for htn (hypertension) and anixety (sic), pt (patient) is a new resident and the doctor has not signed of (off) on patients meds (medications) per patients statement...has not has (sic) meds since yesterday at 11 a.m...systolic blood pressure 211...diastolic blood pressure 122...stable...discharged: time 03/12/2016 15:35...no nursing home. Counseled Patient regarding diagnosis..."</p> <p>During an interview on 04/05/16 at 11:38 a.m., LPN #1 indicated she had worked 03/12/16 and was the resident's Nurse. LPN #1 indicated the resident's blood pressure had not been taken prior to 03/12/15 at 11:45 a.m. when the blood pressure was 212/100. LPN #1 indicated the resident had not received the morning dose of metoprolol on 03/12/16 because there were no orders for the medication and she had received orders to continue medications from the Physician an hour prior to the resident going to the hospital and had to wait on Pharmacy to put the</p>			

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	<p>resident's information in the system so she could get the medications out of the Emergency Drug Supply.</p> <p>During an interview on 04/05/16 at 3:10 p.m. LPN #2 indicated the resident was admitted from home and the admission orders she brought with her were from her last hospital stay in February. LPN #2 indicated the resident had brought medication bottles in from home and all the medication labels matched the orders except the narcotic pain medication. LPN #2 indicated some of the bottles had no medications in them. LPN #2 indicated the Physician was notified of the Hospital Orders and the blood pressure and had given an order to continue the hospital discharge orders. LPN #2 indicated the facility didn't know if the resident was going to stay at the facility because she was upset about not being able to smoke, so the resident had not been activated in the computer. LPN #2 indicated she had administered the metoprolol on 03/11/16 around noon. LPN #2 indicated she had not documented the Physician's approval to follow the Hospital Orders and had not documented the metoprolol was given.</p> <p>During an interview on 04/05/16 at 3:35 p.m., LPN #2 indicated she took the metoprolol from the resident's</p>			

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	<p>medications she brought in from home. LPN #2 indicated she had not documented the order to continue the orders from the hospital discharge and had not documented the metoprolol was given.</p> <p>During an interview on 04/05/16 at 3:35 p.m., the Director of Nursing indicated the resident's blood pressure had not been re-assessed after the resident was admitted on 03/11/16 at 11:54 a.m. through 03/12/16 at 11:45 a.m.</p> <p>During an interview on 04/05/16 at 4:09 p.m., Physician #3 indicated he had been notified of the resident's high blood pressure on admission and approved the orders from the Hospital Discharge Orders.</p> <p>This Federal Tag relates to Complaint IN00195929.</p> <p>3.1-37(a)</p>			

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F 0514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</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 record review and interview, the facility failed to ensure a resident's record was complete and accurate, related to documentation of Physician's notification and medication administration, for 1 of 3 resident's records reviewed in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 04/05/16 at 9:27 a.m. The resident's diagnoses included, but were not limited</p>	F 0514	<p>F514 - 1) Resident #B was discharged from the facility prior to the survey. 2) All residents have the potential to be affected by the alleged deficient practice. A chart review noting the completion and accuracy of all resident's records that were admitted or re-admitted over the previous 30 days was completed. Noted concerns were corrected as needed. 3) In-service (re-education) for nurses on the completion and accuracy of resident records was completed. An audit tool checking for completeness and accuracy of the resident's chart will be</p>	04/25/2016

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	<p>to diabetes mellitus, hypertension, and post shoulder surgery.</p> <p>The Admission Orders from a hospital discharge, dated 02/05/16, brought with the resident upon admission to the facility on 03/11/16, included metoprolol (anti-hypertensive) 25 mg XL (long acting), one tablet daily. The resident was admitted from home and brought medications into the facility from home which included the metoprolol (anti-hypertensive) 25 mg XL.</p> <p>A Nurses' Note, dated 03/12/16 at 3:59 p.m., late entry for 11:45 a.m., indicated, "Res (resident) alert and orient. (oriented)...requested to have b/p (blood pressure) taken, upon entering room with b/p machine resident noted to be on phone. resident (sic) hung up phone and stated that she had called 911. residents (sic) b/p 212/100-70 (pulse). resident (sic) requested to go to hospital..."</p> <p>During an interview on 04/05/16 at 11:38 a.m., LPN #1 indicated she had worked 03/12/16 and was the resident's Nurse. LPN #1 indicated the resident's blood pressure had not been taken prior to 03/12/15 at 11:45 a.m. when the blood pressure was 212/100. LPN #1 indicated the resident had not received the morning dose of metoprolol on 03/12/16 because</p>		<p>completed by the DNS/designee. Audits will be conducted 5 times per week for 4 weeks, then 3x per week for 4 weeks, weekly for 4 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting to track and trend for concerns. Finding no patterns, it will then be reviewed quarterly thereafter. Action Plans will be developed for any identified concern. 5) April 25, 2016</p>	

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	<p>there were no orders for the medication and she had received orders to continue medications from the Physician an hour prior to the resident going to the hospital and was waiting on Pharmacy to put the resident's information in the system so she could get the medications out of the Emergency Drug Supply.</p> <p>During an interview on 04/05/16 at 3:10 p.m. LPN #2 indicated the resident was admitted from home and the admission orders she brought with her were from her last hospital stay in February. LPN #2 indicated the Physician was notified of the Hospital Orders and the blood pressure and had given an order to continue the hospital discharge orders. LPN #2 indicated she had administered the metoprolol on 03/11/16 around noon. LPN #2 indicated she had not documented the Physician's approval to follow the Hospital Orders, Physician's notification of the blood pressure, and the metoprolol was given.</p> <p>During an interview on 04/05/16 at 3:35 p.m., LPN #2 indicated she took the metoprolol from the resident's medications she brought from home. LPN #2 indicated she had not documented the Physician's Telephone Order to continue the orders from the hospital discharge and had not</p>			

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

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	<p>documented the metoprolol was given.</p> <p>This Federal Tag relates to Complaint IN00195929.</p> <p>3.1-50(a)(1) 3,1-50(a)(2)</p>			