

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155136	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/30/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVE LA PORTE, IN 46350
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F000000	<p>This visit was for the Investigation of Complaints IN00140057 and IN00142463.</p> <p>Complaint IN00140057- Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F425, and F431.</p> <p>Complaint IN00142463- Substantiated. Federal/state deficiency related to the allegation is cited at F157.</p> <p>Survey dates: January 29 & 30, 2014</p> <p>Facility number: 000061 Provider number: 155136 AIM number: 100288620</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF/NF: 136 Total: 136</p> <p>Census payor type: Medicare: 20 Medicaid: 110 Other: 6</p>	F000000	<p>This Plan of Correction shall serve as this facility's credible allegation of compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the 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. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in this survey. Respectfully Submitted, Beth Ingram Executive Director</p>	

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>Total: 136</p> <p>Sample: 15</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 5, 2014, by Janelyn Kulik, RN.</p>			

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F000157 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 record review and interview, the facility failed to ensure the resident's Physician was notified of a change in condition related to a new onset of leg pain after a recent</p>	F000157	Step One: 1.All medications were obtained from pharmacy for Resident G. 2. Resident K was assessed for pain on 1/10/2014 and the physician was notified with orders obtained for an x-ray	03/01/2014			

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	<p>fall and medications not available from the Pharmacy for 1 of 3 residents reviewed for change in condition for 1 of 3 residents reviewed for availability of medications in the sample of 15 . (Residents #G and #K)</p> <p>Findings include:</p> <p>1. The record for Resident #G was reviewed on 1/29/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, acute and chronic respiratory failure, chronic airway obstruction, high blood pressure, and insomnia with sleep apnea. The resident was admitted to the facility on 11/8/13 at 3:00 p.m.</p> <p>Review of the 11/2013 Order Summary Report indicated there was a Physician's order obtained on 11/8/13 for the resident to receive Advair Diskus Aerosol (an inhaler to help breathing) 250-50 micrograms per dose. The order indicated the resident was to receive one puff twice a day. There was also an order written on 11/8/13 for the resident to receive Lasix (a diuretic medication) 40 milligrams one tablet twice a day. There was also an order for the resident to receive two PhosLo (a</p>		<p>of the right leg. Step Two:1. The medical record was reviewed to ensure appropriate physician notification for all residents who have not received medications timely from the pharmacy during the past 30 days. Any deficiencies noted were corrected.2. The medical record was reviewed to ensure appropriate physician notification for all residents who have exhibited signs or symptoms of pain during the past 30 days. No deficiencies were noted. Step Three:All Licensed Nursing Staff were re-educated regarding the Change in Resident Health Status Policy. The DNS and/or designee will audit 10 medical record weekly to ensure proper physician notification. The findings will be reported to the QAPI Committee monthly. Step Four:The results of the audit for physician notification will be reviewed during the Clinical Start-Up Meeting weekly and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern) the results will be reviewed quarterly.</p>		

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	<p>dietary nutritional supplement) capsules with meals.</p> <p>The 11/2013 Medication Administration Record indicated the Advair Diskus was not administered at 8:00 a.m. on 11/9/13, 11/10/13, and 11/11/13. The Medication Administration Record also indicated the 12:00 p.m. doses of the PhosLo capsules and the Lasix were not administered on 11/17/13 .</p> <p>Review of the 11/2013 Nursing Progress Notes indicated there were entries made on 11/9/13 at 8:36 a.m., 11/9/13 at 8:27 a.m., and 11/11/2013 at 8:36 a.m. These three entries were titled as Medication Administration Notes. The 11/9/13 entry indicated the medication had not been delivered. The 11/10/13 entry indicated the medication had not been sent from the Pharmacy. The 11/11/13 entry indicated the medication had not arrived form the Pharmacy. There was no documentation of Physician notification of the resident not receiving the 8:00 a.m. dose of the Advair Diskus inhaler on 11/9/13, 11/10/13, and 11/11/13.</p> <p>Continued review of the 11/2013 Nursing Progress Notes indicated an</p>				

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	<p>entry was made on 11/17/13 at 12:10 p.m. This entry was titled as a Medication Administration Note. The entry indicated the resident had taken her morning dose (no medication name documented) at 11:00 a.m.. The next entry was made on 11/17/13 at 12:11 p.m. This entry was also titled as a Medication Administration Note. The entry indicated the resident took the morning dose (no medication name documented) at 11:00 a.m. so the mid day dose (no medication name documented) was held. There was no documentation in either of the above entries indicating the Physician had been notified of the resident's morning doses of the Lasix and PhosLo not being administered as ordered.</p> <p>When interviewed on 1/30/14 at 1:00 p.m., Unit Manager #1 indicated the Physician should have been notified of the 8:00 a.m. dose of medications not being given at the ordered time. The Unit Manager also indicated the Physician should have been notified of the Advair Diskus not being available from Pharmacy and not being administered on the above dates.</p> <p>2. The record for Resident #K was</p>			

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	<p>reviewed on 1/29/14 at 8:32 a.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, depressive disorder, dementia, and previous left trochanter and pelvic fractures.</p> <p>The 1/2/2014 Admission Minimum Data Set (MDS) full assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (5). A score of (5) indicated the resident's cognitive patterns were severely impaired. The MDS assessment also indicated the resident required extensive assistance (resident involved in activity with staff providing weight bearing support) of staff members for bed mobility, transfers, dressing, and personal hygiene. The MDS assessment also indicated the resident had fallen prior to admission.</p> <p>The 1/3/2014 Nursing Progress Notes were reviewed. A Change in Condition note was made on 1/3/14 at 5:42 p.m. This note indicated the resident was in the Dining Room and had finished her meal and got up and tried to walk. The note also indicated the Nurse tried to get to the resident but the resident fell on her right side and did not hit her</p>			

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	<p>head. The resident had no complaints of pain and the Physician and the resident's family were notified.</p> <p>A faxed order form dated 1/10/14 at 5:55 p.m. indicated the Physician ordered an X-ray of the right hip and the pelvis to be completed.</p> <p>Review of the 1/10/14 Radiology report indicated right hip and pelvis X-rays were completed. The results indicated the resident had a recent right hip fracture. An LPN signed the bottom of the report and noted the Physician was notified of the results on 1/10/14 at 9:00 p.m..</p> <p>When interviewed on 1/29/14 at 10:15 a.m. PT (Physical Therapist) #1 indicated Resident #K was currently receiving Physical Therapy. The PT staff indicated he provided therapy to the resident prior to her right hip fracture. PT staff indicated the resident was receiving Physical Therapy for a left hip fracture. The PT staff indicated on Thursday 1/9/14, he noticed the resident displayed facial grimacing when staff worked with her right leg and then had no grimacing when he stopped moving the right leg. The PT staff indicated he informed Nursing of</p>						

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	<p>the resident's right leg pain on 1/9/14. PT #1 indicated he completed therapy for the resident again on 1/10/14 and the resident again displayed facial grimacing with right leg movement. PT #1 indicated he informed the Nursing staff of the right leg pain on 1/10/14 also.</p> <p>The 1/9/2014 Nursing Progress Notes were reviewed. There was no documentation of Therapy staff notifying Nursing staff of any complaints of pain. There was no documentation of the resident's Physician being notified of any reported complaints of pain reported by the Physical Therapist on 1/9/14.</p> <p>The 1/10/14 Nursing Progress Notes were reviewed. There was no documentation of Nursing being notified by Therapy of any complaints of pain. An entry made at 4:44 p.m. indicated the resident complained of intermittent pain to the right leg and was able to flex and bend her ankle and knee without difficulty. The entry indicated the resident had occasional pain to the right hip with movement. The Physician was notified.</p> <p>When interviewed on 1/30/14 at 10:15 a.m., LPN #1 indicated</p>			

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	<p>Physical Therapy notified her of the resident's pain during therapy on 1/9/14. The LPN indicated she saw staff toilet and transfer the resident on that day and she displayed no complaints of pain or yelling with care. The LPN also indicated she had given the resident an injection in the right thigh the day before. The LPN indicated the resident was assessed and she did not notice any leg rotation or pain when the resident was stood with both legs on the floor. LPN #1 indicated she did not notify the Physician of Therapy reporting the resident displayed pain on 1/9/14.</p> <p>The facility policy titled "Notification of Change in Resident Health Status" was reviewed on 1/29/14 at 6:45 a.m. There was no date on the policy. The Facility Administrator provided the policy and indicated the policy was current. The policy indicated the resident's Physician, Nurse Practitioner, or Physician Assistant were to be notified of accidents resulting in injuries or requiring Physician interventions, changes in the resident's physical, mental, or psychosocial status, or a need to alter treatment.</p> <p>This Federal tag relates to</p>			

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F000425 SS=D	<p>Complaints IN00140057 and IN00142463.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure pharmaceutical services were available to ensure medications were provided to residents in timely manner for 1 of 3 residents review for medication availability upon admission in the sample of 15. (Resident #G)</p>	F000425	<p>Step One: All medications were obtained from pharmacy for Resident G. Step Two: All current residents were reviewed to ensure the availability of medications. Any deficiencies noted were corrected. Step Three: All Licensed Nursing Staff were re-educated regarding the policy for Provider Pharmacy Requirements. An Unavailable Medication Tacking Log will be</p>	03/01/2014	

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	<p>Findings include:</p> <p>The record for Resident #G was reviewed on 1/29/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to diabetes mellitus, acute and chronic respiratory failure, chronic airway obstruction, high blood pressure, and insomnia with sleep apnea. The resident was admitted to the facility on 11/8/13 at 3:00 p.m. The resident had previously resided at the facility and had recently been discharged prior to her 11/8/13 admission.</p> <p>Review of the 11/2013 Order Summary Report indicated there was a Physician order obtained on 11/8/13 for the resident to receive Advair Diskus Aerosol (an inhaler to help breathing) 250-50 micrograms per dose. The order indicated the resident was to receive one puff twice a day.</p> <p>The 11/2013 Medication Administration Record indicated the Advair Diskus was not administered at 8:00 a.m. on 11/9/13, 11/10/13, and 11/11/13.</p> <p>Review of the 11/2013 Nursing Progress Notes indicated there were</p>		<p>implemented to ensure appropriate intervention and notification occurs. The DNS and/or designee will audit the Unavailable Medication Tacking Log three times weekly and report findings to the QAPI Committee. Step Four: The results of the Unavailable Medication Audit will be reviewed during the Clinical Start-Up Meeting weekly and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern) the results will be reviewed quarterly.</p>				

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	<p>entries made on 11/9/13 at 8:36 a.m., 11/9/13 at 8:27 a.m., and 11/11/2013 at 8:36 a.m. These three entries were titled as Medication Administration Notes. The 11/9/13 entry indicated the medication had not been delivered. The 11/10/13 entry indicated the medication had not been sent from the Pharmacy. The 11/11/13 entry indicated the medication had not arrived from the Pharmacy. There was no documentation of any calls or contacts with the Pharmacy related to the Advair Diskus inhaler not being available on 11/9/13, 11/10/13, and 11/11/13.</p> <p>When interviewed on 1/30/14 at 1:00 p.m. Unit Manager #1 indicated the Pharmacy delivered medications to the facility at approximately 4:00 p.m. and again on the midnight shift daily except on Sundays. The Unit Manager indicated the Nursing staff should have notified the Pharmacy if the medication was not available to make arrangements for delivery or to have the medication obtained from a back up Pharmacy.</p> <p>The facility policy titled "Provider Pharmacy Requirements" was reviewed on 1/19/14 at 2:00 p.m. The policy had a revised date of</p>			

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	<p>November 2011. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated the Pharmacy was required to provide routine and timely pharmacy services seven days a week and emergency service 24 hours per day, seven days per the week. The policy indicated Emergency or "stat" medications were to be available for administration no more then 2 hours after the order was received. The policy also indicated all other medications were to be available for administration as soon as possible on the next routine delivery date. The medications were to be delivered by the primary pharmacy or back-up pharmacy, or the Emergency Drug Kit.</p> <p>This Federal tag relates to Complaint IN00140057.</p> <p>3.1-25(g)(2)</p>				

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F000431 SS=E	<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 interview, the facility failed to ensure opened insulin vials and insulin injection pens were</p>	F000431	Step One: New insulin vials and/or pens were obtained and appropriately dated for Residents G, H, P Q, R, and S. Step Two: All insulin vials or insulin pens	03/01/2014			

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	<p>labeled with the date they were first opened and discarded after the appropriate time for 5 residents residing on 3 of 4 Nursing Units. (Residents #G, #H, #P #Q, #R, and #S) (Rainbow Lane, Memory Lane, and Terrace Garden units)</p> <p>Finding include:</p> <p>1. Insulin storage in the Medication Carts and Medication Refrigerator on the Rainbow Lane was observed on 1/29/14 at 12:30 p.m. with Unit Manager #1.</p> <p>The following was observed:</p> <p>a. An open Novolog Flex Insulin injection Pen was stored in one of the Medication Carts. The Insulin Pen was for Resident #G. The label on the Insulin Pen indicated it was delivered on 9/10/13. The insulin Pen was opened. There was no date on the label or the Pen to indicate when it had first been opened. LPN #3 opened the cap and indicated the pen had been opened and was currently being used. There were no other Insulin Pens in the cart.</p> <p>The manufactures insert for the Novolog Flex Pen was reviewed. The insert indicated a used Novolog</p>		<p>were visually inspected to ensure the medications were opened within the appropriate timeframe. Any deficiencies noted were corrected. Step Three: All Licensed Nurses were re-educated regarding the policy for Preparation and General Guidelins: vials and ampules of injectable medications. The DNS and/or designee will visually inspect all insulin vials and/or pens weekly to ensure the medicaitons are not outdated and findings will be reported tot the QAPI Committee. Step Four:The results of the audit for insulin vials and/or pens will be reviewed during the Clinical Start-Up Meeting weekly and will be ongoing. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern) the results will be reviewed quarterly.</p>				

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	<p>Pen was to be thrown away after 28 days even if there was insulin left in the pen.</p> <p>b. There was an open vial of Lantus insulin in the refrigerator in the Nursing Station. The vial was labeled with Resident #P's name. There was no date indicating the date the vial was first opened.</p> <p>c. There was an opened vial of Humulin N insulin in the second Medication Cart. The vial was labeled with Resident #H's name. The label indicated the insulin vial was opened on 12/29/13.</p> <p>When interviewed at this time, Unit Manager #1 indicated staff were to date the insulin pens and vials when they were first opened. The Unit Manager indicated the insulin was to be discarded after 28 day as per the package insert.</p> <p>2. Storage of Insulin vials in the Medication Carts on the Memory Lane Unit was observed with Unit Manager #2 on 1/29/14 at 12:49 p.m. The following was observed:</p> <p>a. There was an opened vial of Levemir insulin in the second Medication cart. There was no</p>						

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	<p>resident name on the label on the vial. The label indicated the the vial was first opened on 12/26/13. LPN #4 was present at the cart and indicated the insulin was for Resident #S and the resident received the insulin daily in the evening.</p> <p>When interviewed at this time, Unit Manager #2 indicated the above resident was currently receiving the ordered insulin. The Unit Manager indicated the vials were to be discarded 28 days after opening.</p> <p>3. Storage of Insulin vials in the Medication Carts on the Terrace Garden Unit was observed with Unit Manager #3 on 1/29/14 at 12:59 p.m. The following was observed:</p> <p>a. There was an opened vial of Novolog insulin in the first Medication Cart. Resident #R's name was on the vial. The label also indicated the vial was first opened on 12/7/13.</p> <p>b. There was an opened vial of Novolog insulin in the second Medication Cart. Resident #Q's name was on the vial. The label also indicated the insulin vial was first opened on 12/5/13.</p>						

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	<p>When interviewed at this time, the Unit Manager indicated the above residents were receiving the insulin.</p> <p>When interviewed on 1/30/14 at 9:15 a.m., the Director of Nursing indicated all the above insulin vials and pens should have been discarded 28 days after they were first used or opened.</p> <p>The facility policy titled "Preparation and General Guidelines" was reviewed on 1/29/14 at 2:00 p.m. The policy had a revised date of November 2011. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated the guidelines recommended discarding multidose vials at 28 days after opened.</p> <p>This Federal tag relates to Complaint IN00140057.</p> <p>3.1-25(o)</p>			