STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00201888 and IN00202155. Complaint IN00201888 - Substantiated. State deficiency related to the allegation is cited at F9999. Complaint IN00202155 - Substantiated. Federal/State deficiencies related to the allegations are cited at F325. Survey dates: June 28 & 29, 2016 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census bed type: SNF/NF: 141 Total: 141 Census payor type: Medicare: 19 Medicaid: 103 Other: 19 Total: 141 Sample: 3 These deficiencies reflects State findings	F 0000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission of fault by the Living Center, the Executive Director or any employees, agents, or other individuals who draft or may be discussed in this Response and Plan of Correction In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Living Center of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations Accordingly, the Living Center has prepared and submitted this Plan of Correction prior to any resolution of any appeal which may be filed solely because of the requirements under State and Federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition of participation in the Title eighteen (18) and nineteen (19) programs This Plan of Correction is submitted as the Living Center's credible allegation of compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 6/30/16.			
F 0325 SS=G Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review, and interview, the facility failed to maintain acceptable nutritional parameters related to tube feedings not administered at the ordered rate and weekly weights not completed which resulted in a significant weight loss for 1 of 3 residents reviewed for enteral feedings in a sample of 3. (Resident # C) Finding includes: On 6/28/16 at 8:21 a.m., Resident #C was observed asleep in bed. The head of the	F 0325	The Living Center respectfully requests that an Informal Dispute Resolution be granted on the basis of Resident "C"'s weight loss does not meet the definition of a significant weight loss which did not warrant a scope and severity of actual harm What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident "C"s tube feeding regimen rate was changed as ordered per the physician and weekly weights are completed. Resident C's tube feeding regimen and oral intake is	07/18/2016

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	resident's bed was elevated. The resident was receiving a tube feeding through a gastrostomy tube (a tube placed into the abdomen used to administer liquid nutrition and medications). Vital 1.5 tube feeding formula was infusing through the gastrostomy tube via a pump at 35 cc's (cubic centimeters) per hour. On 6/28/16 at 9:36 a.m., 10:55 a.m., 12:20 p.m., and 1:40 p.m., the resident remained in bed. The Vital 1.5 tube feeding continued to infuse at 35 cc's per hour. The resident's record was reviewed on 6/28/16 at 10:40 a.m. The resident was admitted to the facility on 6/1/16. The resident's diagnoses included, but were not limited to, acute respiratory failure, high blood pressure, and dysphagia (difficulty swallowing). A Physician's order written on 6/24/16 indicated the Vital 1.5 tube feeding formula rate was to be increased 10 cc's every (8) hours until a goal rate of 65 cc's per hour was reached. A Physician order was written on 6/4/16 for the resident to remain NPO (to receive nothing by mouth). Review of the 6/8/16 Minimum Data Set (MDS) Admission assessment indicated the resident was rarely or never understood. The assessment indicated		monitored and reviewed weekly to ensure adequate nutrition. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be identified and what corrective action will be taken: The Living Center realizes that all other residents with a tube feeding regimen have the potential to be affected by the alleged deficient practice. No other resident were affected. All other resident's with a tube feeding regimen were reviewed to ensure the infusion rates were appropriate as per the physician's order and no significant weight loss was identified related to regimen. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: Nursing staff have been re-educated regarding Administration of Tube Feed Policy and completion of weekly weight guidelines by the DNS/ADNS by 07/15/2016. The Living Center developed an auditing tool to be implement as a systemic change. Weight Management Interdisciplinary Team will continue to review and manage residents with weekly weights per facility policy guidelines. The CNA weight team will be established with tasks to obtain weekly weights as ordered to decrease weight variances. CNA	

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	the resident was dependent on staff for eating, hygiene and bathing. The assessment indicated the resident received tube feeding and was not on any mechanically altered oral diet. The assessment also indicated the resident received 51% or more of his nutrition via a parental or feeding tube route. Review of the resident's current Care Plans indicated a Nutritional Care Plan was initiated on 6/13/16. The Care Plan indicated the resident was dependent on tube feeding related to a diagnosis of dysphagia. The Care Plan also indicated the resident was NPO. Care Plan interventions included, but were not limited to administer the enteral tube feeding as ordered and monitor weights. A Nutrition Assessment was completed by the Registered Dietitian on 6/3/16. The assessment indicated the resident was NPO (to receive nothing by mouth) and received nutrition via the tube feeding formula. The Nutrition Assessment also indicated the resident's nutritional status would be monitored by weekly weights. Review of the resident's 6/2016 weights indicated the following weights were recorded: 6/2/2016: 142.0 pounds		weight team will start obtaining weekly weights and the IDT will then meet weekly for final review. How the corrective action(s) will be monitored to ensure the alleged deficient practice does not recur i.e., what quality assurance program will be put into place: The DNS or her designee will monitor by use of the auditing tool five (5) residents with a tube feeding regimen per day five (5) times per week at various times of the day for the next twelve (12) weeks, then 3 times per week at various times of the day for the next twelve (12) weeks. Residents with tube feeding regimen will have weights audited weekly for 6 months. All findings will be forwarded to the monthly Quality Assurance Process Improvement Committee for further review and recommendations as necessary.	

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	6/6/2016: 142.0 pounds 6/22/2016: 138 pounds 6/28/2016: 135.2 pounds. A weight of 135 pounds reflected 5% significant weight loss in less then 30 days. When interviewed on 6/28/16 at 2:50 p.m., the Director of Nursing indicated there was a Physician's order written on 6/24/16 to increase the rate of the tube feeding. The Director of Nursing indicated the tube feeding rate should have been increased as ordered by the Physician on 6/24/16. This Federal tag relates to Complaint IN00202155. 3.1-46(a)(1)			
F 9999 Bldg. 00	STATE RULES: 3.1-13 Administration and Management If the facility does not employee a qualified professional person to furnish a	F 9999	It is the intent of the Living Center to ensure agency staff members receive orientation to the facility's pertinent policies and procedures. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient	07/18/2016

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	specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under a written agreement. Such agreements pertaining to services furnished by outside resources must specify, in writing that the facility assumes responsibility for Orientation to pertinent facility policies and residents to whom they are responsible. THIS STATE RULE WAS NOT MET AS EVIDENCED BY: Based on record review and interview, the facility failed to ensure Agency staff members received Orientation to the facility's pertinent policies and procedures for 16 of 16 Agency staff utilized in June 2016. (Agency Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #14, #15, #16, #17) Finding includes The Employee Records for Agency Staff utilized between 6/1/16 and 6/27/16 were reviewed on 6/28/16 at 12:00 p.m. The Agency staff were provided by two different staffing Agencies. The facility utilized (16) Agency staff during 6/2016. There was no verification of the following Agency staff completing a "Nursing Agency Orientation" to confirm		practice: Resident C's tube feed rate was corrected on 6/29/16. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken: The Living Center realizes that all residents could have the potential to be affected by the alleged deficient practice. No other residents were identified. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: All contracted staff will have the appropriate orientation of pertinent Living Center's policies and procedures, Fire and disaster plan, Resident's Rights and Dignity, Abuse, Neglect, and misappropriation of property, shift routine, location of supplies/equipment, lines of communication and supervision, specialty programs if assigned to those areas, and the documentation policies with access to electronic health records. Orientation will occur prior to being allowed to assume duties in the Living Center by use of an updated "Nursing Agency Orientation" form that will be signed by the agency nursing personnel and the employee conducting the orientation. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur i.e. what quality assurance program will be put into place: Binders with	

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	the staff had received orientation. A "Nursing Agency Orientation" form was reviewed. The form indicated Agency staff were to initial the form to validate their orientation to the facility practices and protocols for Center Fire and Disaster Plan, Resident Rights and Dignity, Abuse, Neglect, and Misappropriation of Property Policies, Shift Routine, Location of Supplies/Equipment, Lines of Communication and Supervision, Specialty programs if assigned to to those areas, and the Documentation Policies with Access to electronic health records. The above form was to be signed by the Agency staff member and also the Facility employee completing the Orientation. Agency #1 (LPN) worked at the facility on 6/1/16, 6/2/16, 6/8/16, 6/9/16, 6/16/16, and 6/20/16. Agency #2 (LPN) worked at the facility on 6/2/16, 6/5/16, 6/11/16, 6/12/16, 6/18/16, and 6/19/16. Agency #3 (LPN) worked at the facility on 6/3/16. Agency #4 (LPN) worked at the facility on 6/3/16, 6/5/16, and 6/6/16.		"Nursing Agency Orientation" forms and policy and procedures will be located at each nursing station in order to ensure accessibility for off hours/weekend use. The forms will be collected daily Monday through Friday by the DNS/Designee to confirm orientation completion for duration of agency usage.	

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	Agency #5 (LPN) worked at the facility on 6/3/16, and 6/14/16. Agency #6 (CNA) worked at the facility on 6/4/16, and 6/11/16. Agency #7 (CNA) worked at the facility on 6/4/16, and 6/10/16. Agency #8 (CNA) worked at the facility on 6/4/16, 6/5/16, 6/7/16, and 6/9/16. Agency #9 (LPN) worked at the facility on 6/5/16, 6/7/16, 6/9/16, 6/10/16, 6/11/6, 6/12/16, 6/15/16, 6/16/16, 6/17/16, and 6/23/16. Agency #10 (LPN) worked at the facility on 6/10/16, 6/13/16, 6/17/16, and 6/23/16. Agency #11 (CNA) worked at the facility on 6/10/16. Agency #12 (LPN) worked the facility on 6/10/16, 6/14/16, 6/21/16, and 6/22/16. Agency #14 (CNA) worked on 6/9/16. Agency #15 (CNA) worked on 6/19/16, 6/25/16, and 6/26/16. Agency #16 (LPN) worked on 6/21/16.			

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	Agency #17 (LPN) worked on 6/24/16, 6/25/16, 6/26/16. The above (16) Agency Staff did not have the above Nursing Agency Orientation forms completed. The Supplemental Staffing Agreement contract with Agency#1 was reviewed on 6/29/16 at 10:45 a.m. The contract indicated the purpose of the agreement was to define the responsibilities between the Agency and Golden Living Fountainview Place. The contract indicated the facility was responsible to provide orientation which included review of policies and procedures regarding medication administration, documentation procedures regarding medication administration, documenting procedures, patient rights, infection prevention, Fire & Safety, and charting. When interviewed on 6/28/16 at 1:00 p.m., the Scheduler indicated there had been several internal staff changes and Agency staff were being employed. The Scheduler indicated the completed and signed "Nursing Agency Orientation" forms should have been completed by all Agency staff who worked in the facility. The Scheduler indicated the she had some Agency files and the DCS (Director			

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	of Clinical Services) also kept some files. When interviewed on 6/29/16 at 10:35 a.m., the Administrator indicated Agency staff members were to have completed Orientation verification available. This State tag relates to IN00201888. 3.1-13(m)(3)			