STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 00 B. WING	06/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVE LA PORTE, IN 46350

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00201699. Complaint IN00201699 - Substantiated. Federal/State deficiencies related to the allegation are cited at F315. Survey dates: June 13 & 14, 2016 Facility number: 000061 Provider number: 155136 AIM number: 1002886620 Census bed type: SNF/NF: 127 Total: 127 Census payor type: Medicare: 13 Medicaid: 92 Other: 22 Total: 127 Sample: 5 This deficiency reflects State findings in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 6/15/15.	F 0000	This Plan of Correction shallserve as this facility's credibleallegation of compliance.Preparation, submission, andimplementation of the Plan ofCorrection does not constitue anadmission of or agreement withthe facts and conclusions setforth in this survey report. OurPlan of Correction is preparedand executed as a means tocontinuously improve the qualityof care and to comply with allapplicable state and federalregulatory requirements. Pleaseconsider allowing the submissionof living center audits andeducation as evidence ofcompliance with the state andfederal requirements identified inthe survey. Respectfully, JerrellHarville, HFA, MSW, ExecutiveDirector.	

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

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F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure Laboratory test results were obtained timely which resulted in a delay of initiating the correct medication for 1 of 3 residents reviewed for Urinary Tract Infections in a sample of 5. (Resident #C) Finding includes: The record for Resident #C was reviewed o 6/13/16 at 9:37 a.m. The resident's diagnoses included, but were not limited to, paraplegia, anemia, diabetes mellitus, high blood pressure, and heart failure. The resident was sent to the hospital on 5/17/16.	F 0315	Step 1: The identified resident has discharged from the facility. Step 2: All residents with lab orders were assessed for timelinessof results being obtained. Anydeficiencies noted were corrected. Step 3: LicensedStaff were re-instructed on the process of ensuring lab results have beenreceived timely. The DNS or herdesignee will audit 3 random residentswith lab orders per unit weekly to ensure timeliness of lab results. The DNSwill report findings to the QAPIcommittee monthly. Step 4: The results of the lab audits will be reviewed inthe Clinical Start Up Meeting weekly. The results will also be reviewed monthly by the QAPI committee for sixmonths. If after six months of review without any	07/08/2016

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	Review of the 5/11/16 Minimum Data Set (MDS) Significant Change assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (13). A score of (13) indicated the resident's cognitive patterns were intact. The assessment indicated the resident required extensive assistance of two staff members for personal hygiene, transfers, and dressing. Review of a Care Plan initiated on 4/20/16 indicated the resident was at risk for infections related to an UTI (Urinary Tract Infection.) Care plan interventions included, but were not limited to, administer antibiotics as ordered, monitor for adverse reactions, follow contact precautions, and update the Physician as needed. The 4/2016 Laboratory test results were reviewed. Results of a Urinalysis test collected on 4/15/16 at 4:00 a.m. indicated the test results were as follows: Ketones 1+ (normal is negative) Bacteria 1+ (normal is negative) WBC's (White blood cells) TNTC (to numerous to count) The results page indicated the above results were faxed to the facility on 4/18/16 at 11:41 p.m. The Nurse Practitioner signed the results on 4/19/16 (no time listed.)		trends or patterns noted (3deficient practices will be considered a trend or pattern) the results will bereviewed quarterly.	

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	Culture results on 4/23/16 indicated a urine specimen collected on 4/20/16 showed greater then 100,000 of Proteus mirabilis (a bacteria) and greater then 100,000 Klebsiella (a bacteria) and the results were phoned to staff at the facility on 4/23/16 at 1:34 p.m. The results also indicated the specimen was positive for ESBL(Probable Acquired - Extended Spectrum Beta-Lactamase) infection. The report also indicated decrease activity could occur with Cephalosporins (a class of antibiotics). The above was phoned to the facility. The Suspectibilty Results were sent to the facility on 4/28/16 at 10:45 a.m. from the hospital. The results noted the bacteria were not susceptible to Keflex (a Cephalosporins). The results indicated the bacteria was susceptible to Levaquin. The 4/2016 Nursing Progress Notes were reviewed. An entry made on 4/14/16 at 5:09 p.m. indicated new orders were obtained from the Nurse Practitioner for an UA and C&S (urinalysis with culture and sensitivity) due the resident's increased confusion. The Laboratory was notified. The resident was notified of the order. An entry made on 4/15/16 at 4:46 a.m.			

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	indicated the urine specimen was collected and picked up by the Laboratory. An entry made on 4/19/16 at 4:30 a.m. indicated the resident was upset and tearful and claimed a yellow cat had been in her room for the past 2 weeks. An entry made on 4/19/16 at 4:48 p.m. indicated new orders were received from the Nurse Practitioner for a Stat UA and C&S (Culture & Sensitivity) to be done. An entry made on 4/19/16 at 10:07 p.m. indicated the resident's urine was yellow with sediment and a foul odor. An entry made on 4/20/16 at 9:55 a.m. indicated there was a new order to start Keflex (an antibiotic) 500 milligrams twice a day for 10 days. A Change of Condition note completed at 10:32 p.m. indicated the resident had increased confusion. An entry made on 4/28/16 at 11:04 a.m. indicated the Nurse Practitioner was in and reviewed the C&S (Culture and Sensitivity) and new orders were received to discontinue the Keflex and start Levaquin (an antibiotic) Review of the 4/2016 Physician Orders indicated an order was written on 4/20/16 for the resident to receive Keflex (an			

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	antibiotic) 500 milligrams twice a day for 10 days. An order was written on 4/28/16 for the resident to receive Levaquin (an antibiotic) 500 milligrams once a day until 6/6/16. The 4/2016 Medication Administration Record was reviewed. The initial dose of Keflex 500 milligrams was signed out as given on 4/20/16 at 8:00 p.m. The initial dose of Levaquin 500 milligrams was administered on 4/29/16 at 8:00 a.m. Keflex. When interviewed on 6/13/16 at 3:10 p.m., the Director of Nursing indicated the facility had a contract with an outside company to complete their laboratory tests. The Director Nursing indicated some lab specimens were sent out of State to be completed and others were sent to the area hospital to be completed. The Director of Nursing indicated the results of the ESBL bacteria were phoned to a Nurse on 4/23/16 and the resident was placed on isolation. When interviewed on 6/13/16 at 11:20 a.m., the Director of Nursing indicated the facility did not have a specific policy defining the time frame tests results should be completed. The Director of Nursing indicated the susceptibility should have been reported in 2-3 days.			

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	The Director of Nursing indicated there was no record of staff attempting to call the Laboratory to check on the susceptibility prior to 4/28/16 and there was a delay in the resident receiving an effective antibiotic to treat the ESBL infection Urinary Tract Infection. 3.1-41(a)(2) This Federal tag relates to Complaint IN00201699.			