| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155187 | A. BUILDING 00<br>B. WING | 05/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00347399, IN00347926, and IN00350024.<br><br>Complaint IN00347399 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686 and F692.<br><br>Complaint IN00347926 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600.<br><br>Complaint IN00350024 - Substantiated. No deficiencies related to the allegations were cited.<br><br>Survey dates: April 29, 30, May 3, 4, 5, and 6, 2021<br><br>Facility number: 000098<br>Provider number: 155187<br>AIM number: 100290980<br><br>Census Bed Type:<br>SNF/NF: 113<br>Total: 113<br><br>Census Payor Type:<br>Medicare: 7<br>Medicaid: 93<br>Other: 13<br>Total: 113<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 5/10/21. | F 0000 | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his | | | |

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| | or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to an incontinent brief exposed in the hallway, food debris on a resident's face, and wearing a hospital gown in bed during the day for 3 of 3 residents reviewed for dignity. (Residents 16, 72, and 99)<br><br>Findings include:<br><br>1. On 5/4/21 at 9:10 a.m., Resident 16 was observed sitting in a broda chair in front of the nurses' station. She was dressed only in a shirt and was covered with a top sheet. She was observed to have food on her face and chin, and her shirt was stained. The top sheet was hanging off of her chair and exposing her incontinent brief. Numerous staff walked by her and did not pick up the sheet and cover her up or wipe her face.<br><br>At 9:20 a.m., CNA 3 picked up the sheet and covered her up and pushed the chair to her room. The CNA did not speak to the resident and did not tell her where she was going.<br><br>At 2:00 p.m., the resident was observed in bed. She was observed wearing the same stained shirt that she had on earlier in the day.<br><br>The record for Resident 16 was reviewed on 5/3/21 at 2:45 p.m. Diagnoses included, but were not limited to, dementia, major depressive disorder, and anxiety.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 2/9/21, indicated the resident rarely understood and was severely impaired for | F 0550 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 16's face was cleaned and was placed back into bed on 5.4.2021. Resident 72's preferences were reviewed on 5.15.2021 and preferences updated. Resident 99's preferences were reviewed and added to CNA care card on 5.4.2021.<br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Whole house audit completed on 5.21.2021 with no residents identified.<br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Education to nursing staff regarding resident preferences and appropriate appearances for residents completed on 5.21.2021.<br>4. How the corrective action will be monitored to ensure the deficient practice will not recur:<br><br>DNS/Designee to audit resident attire and appearance for 15 residents 5 times a week for 4 weeks, then 15 residents 3 times | 05/28/2021 |

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| | decision making. She needed extensive assist with a 2 person physical assist with bed mobility, transfers, dressing, and personal hygiene.<br><br>Interview with the Interim Executive Director and the Interim Director of Nursing on 5/5/21 at 8:35 a.m., indicated staff should have stopped and covered the resident so her brief was not exposed.2. On 5/3/21 at 9:33 a.m., Resident 72 was observed in bed with his eyes closed. He was dressed in a hospital gown. At 12:40 p.m. and 2:15 p.m., he remained in bed wearing a hospital gown.<br><br>On 5/4/21 at 12:50 p.m. and 2:24 p.m., the resident was observed in bed wearing a hospital gown.<br><br>On 5/5/21 at 9:22 a.m., the resident was observed in bed wearing a hospital gown.<br><br>The record for Resident 72 was reviewed on 5/3/21 at 9:58 a.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia, chronic obstructive pulmonary disease and hypertension.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/17/21, indicated the resident was severely cognitively impaired for decision making and required a physical 2 person assist with bed mobility, transfers, and personal hygiene.<br><br>A revised Care Plan, dated 5/3/21, indicated the resident had a self care deficit. The interventions included, but were not limited to, provide verbal cues and physical assistance as needed to complete the task.<br><br>The resident did not have a Care Plan related to | | weekly for 4 weeks, then 15 residents weekly for 4 months. Audits will be submitted to QAPI monthly for 6 months with compliance percentage. Frequency may change based on percentage of compliance. | |

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| | wearing a gown instead of clothes or remaining in bed during the day.<br><br>Interview with the B Wing Unit Manager on 5/5/21 at 1:20 p.m., indicated the staff should have assisted the resident with dressing and transferring from his bed daily.3. On 5/3/21 at 4:11 p.m., Resident 99 was observed in bed wearing a hospital gown.<br><br>On 5/4/21 at 9:15 a.m., the resident was observed in bed wearing a hospital gown.<br><br>Resident 99's record was reviewed on 5/4/21 at 8:45 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and high blood pressure.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 4/7/21, indicated the resident had short and long term memory problems and was moderately impaired for daily decision making. She required total assistance with dressing.<br><br>The record lacked a Care Plan or Nurses' Notes for refusals or any preference to wear a hospital gown instead of clothes during the day.<br><br>Interview with CNA 4, on 5/4/21 at 10:30 a.m., indicated she lacked information related to the resident's preferences on her "Care Card Sheet" that provided information about the residents. CNA 4 was unaware as to why the resident was wearing a hospital gown.<br><br>Interview with the MDS Coordinator on 5/4/21 at 2:30 p.m., indicated she had just updated the resident's care plan for a preference to wear a hospital gown when in bed during the day after she had talked to the staff. | | | |

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| | 3.1-3 (t) | | | |
| F 0600<br>SS=D<br>Bldg. 00 | 483.12(a)(1)<br>Free from Abuse and Neglect<br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; | | | |
| | Based on record review and interview, the facility failed to implement a system to prevent misappropriation of resident property related to missing narcotics for 2 of 2 allegations of misappropriation of property reviewed. (Residents B and F)<br><br>Finding includes:<br><br>On 5/4/21 at 2:00 p.m., an allegation of misappropriation of property related to missing narcotics was reviewed. The incident occurred on 2/16/21, medications were dispensed from the automatic drug dispensing unit under RN 1's name. Narcotics for Resident B were not accounted for. RN 1 was suspended. The police were notified and an investigation was initiated.<br><br>Abuse audits were completed and Social Services | F 0600 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident B and F's medications were replenished by facility and no medication administration was missed.<br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Whole house audit completed on 4.10.2021 with no other residents affected.<br>3. What measures will be put into place and what systemic changes will be made to ensure that the | 05/28/2021 |

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| | was to assess the resident for signs and symptoms of distress. A pain assessment for the resident was completed and no issues were noted.<br><br>Follow up documentation, completed on 2/22/21, indicated the facility was unable to substantiate that RN 1 had diverted any medications. It was discovered that LPN 5 had paused the (ADU) Automated Dispensing Unit to obtain as needed (PRN) medications and they were dispensed under RN 1's name. LPN 5 was terminated from employment. A (UDS) Urine Drug Screen was obtained and an investigation was initiated. The alleged affected residents had assessments completed with no findings noted. Families and Physicians of all residents were notified. Additional information was given to the local police department. An initial report was made to the Attorney General. The facility pharmacy was working to identify any reimbursement obligations. A year to date whole house narcotic medication reconciliation was completed by pharmacy with no negative findings noted. A year to date PRN narcotic Electronic Medication Administration Record reconciliation was completed. Abuse audits were conducted with no issues. Pain assessments were completed for all residents with no abnormal issues noted. Staff education was completed to all licensed staff regarding resident's rights and abuse. A new ADU system was put in place for witnessing PRN narcotic medication pulls from the ADU. Audits will be ongoing and system changes had been put thru Ad Hoc QAPI.<br><br>Interview with the corporate Vice President of Regulatory Commission on 5/5/21 at 1:22 p.m., indicated the former Director of Nursing received a phone call about possible missing medications and an investigation was started. It was felt the | | deficient practice does not recur: Education for Licensed Nurses and QMAs on correct procedure for verification of narcotic count accuracy to be completed on 5.21.2021.<br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>DNS/Designee to audit narcotic count sheets, ADU narcotic removal report, narcotic bingo card forms, pharmacy delivery manifest of narcotics and number of narcotic sheets 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then twice weekly for 4 months. All audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |

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| | issue started on the Alzheimer's Care Unit (ACU) and the D hall. It was also determined there were issues on other units. She was not sure how many residents were involved.<br><br>A new form was initiated, related to signing in and out of the medication room and reason for being in there. A system was implemented if staff were pulling routine medications, a second nurse as a witness was not needed. If pulling prn narcotics a second nurse must witness the pull and sign the sheet as well. Under no circumstances were staff to leave the ADU while signed in and medications were being dispensed. Staff must stay in the medication room until all medications were completely dispensed and they were signed out of the ADU.<br><br>An undated Ad Hoc QAPI form was placed in the investigation binder. The form indicated measures were put in place/systemic changes to ensure deficient practice doesn't recur: Staff education was initiated for all licensed nursing staff on the process of pulling medications from the ADU. Staff education was provided to all licensed staff regarding resident rights and abuse as pertaining to misappropriation of property/medications. A system was put into place to have 2 nurses present when pulling any prn narcotic medications. Any RN or LPN hired would have education upon hire on the process of pulling medications from the ADU to include not leaving the ADU while signed in.<br><br>The system put into place did not address any other medication storage area, including the medication carts on the unit.<br><br>An allegation of misappropriation of property for Resident F related to missing narcotics, dated | | | |

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| | 4/10/21, was reviewed. On 4/10/21, the Executive Director was notified at 11:00 a.m., that a card of oxycodone 7.5/325 milligram (mg) 30 tablets were unaccounted for. Validation of 5 pharmacy narcotic sheets printed from the pharmacy were in the shredder and replaced with 4 hand written narcotic sheets. Medications were delivered and signed for on 4/9/21 at approximately 3:30 a.m. The hand written sheets were similar to RN 1's writing. RN 1 worked the 3-11 shift on 4/9/21.<br><br>On 4/10/21, the local police department was contacted. Nursing staff who had access to the medication cart had been contacted for interviews and drug screens. The investigation was ongoing. Resident F had 4 cards of medications rather than 5 and the facility would continue to administer the medication according to the physician's order. RN 1 had been called and would be notified of her suspension pending the outcome of the investigation.<br><br>The facility initiated additional measures of narcotic count validation as of 12:00 p.m. on 4/10/21. An audit had been conducted to review other narcotics with the assistance of pharmacy and no other discrepancies were identified.<br><br>A statement provided by QMA 3 on 4/11/21, indicated on 4/9/21 she recalled seeing and counting 5 bingo cards that had 30 tablets each of oxycodone 7.5 -325 milligrams (mg) for Resident F.<br><br>Follow up to the investigation, dated 4/16/21, indicated the resident was assessed with no concerns noted. Upon review, the resident did not miss any doses of medication. The unaccounted for medications would be replaced by pharmacy at the facility's expense. The police had been involved since the beginning of the investigation. | | | |

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| | The facility was unable to substantiate exactly what occurred but would continue working with the detectives involved. A medication reconciliation was conducted with no other concerns noted. A new medication count system was implemented.<br><br>Interview with the Interim Director of Nursing (DON) on 5/4/21 at 11:30 a.m., indicated she was informed the narcotics were missing by another staff member who indicated it looked like medications were being signed out under her name when she had not been working. The Interim DON indicated RN 1 had placed her resignation letter in her mailbox before she was able to talk to her. RN 1 was called and refused to come in saying she was out of town. The Interim DON told the RN she needed to see her and an appointment was set up for Monday at 8:00 a.m. The DON indicated the RN did not show up and she would not answer any further phone calls.<br><br>This Federal tag relates to Complaint IN 00347926.<br><br>3.1-28(a) | | | |
| F 0677<br>SS=E<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to nail care, hair care, and facial grooming for 4 of 5 residents reviewed for ADL's. (Residents 6, 88, 16, and 99) | F 0677 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 6's nails were trimmed on 5.4.21, Resident 88 and 99's facial hair was trimmed on 5.4.21, | 05/28/2021 |

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| | Findings include:<br><br>1. On 4/30/21 at 11:00 a.m., Resident 6 was observed with long fingernails on both hands, the right slightly longer than the left.<br><br>Interview with the resident at that time, indicated he had asked for his nails to be cut several times.<br><br>On 5/3/21 at 9:55 a.m., 11:38 a.m., and 2:22 p.m., the resident was in his room. His nails remained long and in need of cutting.<br><br>The record for Resident 6 was reviewed on 5/3/21 at 11:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes and weakness.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 2/3/21, indicated the resident was cognitively intact for daily decision making and required extensive assistance for personal hygiene.<br><br>The Care Plan, dated 8/3/20 and reviewed 2/2021, indicated the resident had a physical functioning deficit related to a self care impairment due to having a left below the knee amputation. There were no interventions related to hygiene and bathing.<br><br>Interview with the Interim Director of Nursing (DON) on 5/4/21 at 2:00 p.m., indicated since the resident was a diabetic, the CNA's could not cut the resident's nails and she would tell nursing.<br><br>Interview with the Interim DON on 5/5/21 at 9:00 a.m., indicated the resident's nails were cut by nursing staff after he returned from dialysis on 5/4/21. | | Resident 16's hair was combed.<br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.<br>Whole house audit completed on 5.21.21 and no other residents were identified.<br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice dose not recur:<br>Nursing staff education on hair and nail care completed by 5.28.21<br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>DNS/Designee will audit 15 resident's nail/hair 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 months. Audits will be submitted to QAPI monthly for 6 months with compliance percentage.<br>Frequency may change based on percentage of compliance. | |

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| | 155187 | A. BUILDING 00<br>B. WING | 05/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | 2. On 4/30/21 at 10:06 a.m., Resident 88 was observed with a growth of facial hair on her upper lip and chin.<br><br>Interview with the resident at that time, indicated if she had a razor, she would remove the hair herself.<br><br>On 5/3/21 at 9:55 a.m., 11:38 a.m., and 2:22 p.m., the resident was observed in her room in bed. The facial hair to the resident's upper lip and chin remained.<br><br>On 5/4/21 at 9:22 a.m., 10:55 a.m., and 1:10 p.m., the resident was observed in her room in bed. The facial hair to the resident's upper lip and chin remained.<br><br>The record for Resident 88 was reviewed on 5/4/21 at 8:16 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, stroke, and flaccid hemiplegia (muscle weakness on one side).<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 4/2/21, indicated the resident had short and long term memory problems and was moderately impaired for daily decision making. She required extensive assistance for personal hygiene.<br><br>Interview with the Interim Director of Nursing on 5/4/21 at 2:00 p.m., indicated she would have the CNA's assist the resident with her facial hair. 3. On 4/29/21 at 8:51 a.m., Resident 16 was observed seated in a broda chair in her room. At that time, her hair was uncombed and disheveled.<br><br>On 5/3/21 at 9:55 a.m., the resident was observed sitting up in a broda chair in her room next to her | | | |

bed. At that time, her hair was uncombed.

On 5/4/21 at 9:10 a.m., the resident was observed sitting in a broda chair in front of the nurses' station. She was dressed only in a shirt and was covered with a top sheet. Her hair was uncombed and disheveled.

The record for Resident 16 was reviewed on 5/3/21 at 2:45 p.m. Diagnoses included, but were not limited to, dementia, chronic respiratory failure, major depressive disorder, and anxiety.

The Significant Change Minimum Data Set (MDS) assessment, dated 2/9/21, indicated the resident rarely understood and was severely impaired for decision making. She needed extensive assist with a 2 person physical assist with bed mobility, transfers, dressing, and personal hygiene.

A Care Plan, dated 4/10/19, indicated the resident had a physical functioning deficit related to self care impairment and decline was anticipated due to end of life services with hospice.

Interview with the Interim Executive Director and the Interim Director of Nursing on 5/5/21 at 8:35 a.m., indicated the resident's hair should have been combed when sitting up in her chair.4. On 5/3/21 at 4:11 p.m., Resident 99 was observed in bed. She had a heavy growth of facial hair.

On 5/4/21 at 9:15 a.m., the resident was observed in bed and the heavy growth of facial hair remained.

Resident 99's record was reviewed on 5/4/21 at 8:45 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and high blood pressure.

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| | The Quarterly Minimum Data Set (MDS) assessment, dated 4/7/21, indicated the resident had short and long term memory problems and was moderately impaired for daily decision making. She required extensive two person assistance with personal hygiene.<br><br>The record lacked a Care Plan or Nurses' Notes for refusals or any preference to have facial hair.<br><br>Under "Tasks" for personal hygiene, which included, "How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)," indicated the resident received personal hygiene on 4/30/21 at 12:06 a.m., 6:42 a.m. and 2:20 p.m., 5/1 at 7:41 a.m., and 5/3/21 at 11:29 a.m., 2:04 p.m. and 9:59 p.m.<br><br>Interview with CNA 4, on 5/4/21 at 10:30 a.m., indicated she lacked information related to the resident's preferences on her "Care Card Sheet" that provided information about the residents. The resident also lacked a schedule for bathing, and had no refusals of care in the "Bathing Binder."<br><br>Interview with the MDS Coordinator on 5/4/21 at 2:30 p.m., indicated she had just updated the resident's care plan for refusals of personal hygiene after she had talked to the staff.<br><br>3.1-38(a)(3)(B)<br>3.1-38(a)(3)(D)<br>3.1-38(a)(3)(E) | | | |
| F 0679<br>SS=D<br>Bldg. 00 | 483.24(c)(1)<br>Activities Meet Interest/Needs Each Resident<br>§483.24(c) Activities. | | | |

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| | §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. | | | |
| | Based on observation, record review and interview, the facility failed to ensure an ongoing activity program was implemented for cognitively impaired, and dependent residents for 1 of 3 residents reviewed for activities. (Resident 16)<br><br>Finding includes:<br><br>On 5/3/21 at 9:55 a.m., Resident 16 was observed sitting in a broda chair in her room next to her bed. At that time, there was no radio or television turned on for the resident. The resident was awake.<br><br>On 5/3/21 at 12:20 p.m., the resident was observed in bed. Her lunch tray was observed on the over bed table. At that time, there was no radio or television turned on for the resident. The resident was awake. At 2:25 p.m., the resident was still observed in bed and there was no radio or television turned on.<br><br>On 5/4/21 at 9:25 a.m. and 10:40 a.m., the resident was observed in bed. At those times, there was no television or radio turned on. The resident's roommate had on a television, however, the privacy curtain was pulled between the residents. The resident was awake both times. | F 0679 | **F 679**<br><br>**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**<br>**Resident 16 continues to be on one on one activity visits in her room. Television was turned on 5.5.21 and a radio will be provided.**<br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**<br>**Whole house audit conducted with no other residents were identified.**<br>**3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br>**Activity Director education on ongoing activity programming on 5.14.21**<br>**4. How the corrective action** | 05/28/2021 |

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| | On 5/4/21 at 2:00 p.m., the resident's door was closed. She was observed in bed, awake with no television or radio turned on.<br><br>On 5/4 and 5/5/21 at 2:00 p.m., there were group activities going on in the main dining room.<br><br>The record for Resident 16 was reviewed on 5/3/21 at 2:45 p.m. Diagnoses included, but were not limited to, dementia, chronic respiratory failure, major depressive disorder, and anxiety.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 2/9/21, indicated the resident rarely understood and was severely impaired for decision making. She needed extensive assist with a 2 person physical assist with bed mobility, transfers, dressing, and personal hygiene.<br><br>A Care Plan, dated 5/3/21, indicated the resident required 1 to 1 activities and stop-by visits due to her cognitive status. The approaches were to offer activities that were familiar. Provide a variety of independent arts and craft projects, and provide tactile stimulation like hand massages and textured objects.<br><br>The significant change recreational service assessment, dated 2/4/21, indicated the resident was read short stories during 1 to 1 visits. The resident previously enjoyed cooking and crafts, however, due to her cognitive decline she was unable to participate. The resident watched various shows and movies in her room and was provided with nail care and hand massages. The resident liked dogs, cats, and monkeys and socialized with activity staff during 1 to 1 visits. The resident was able to make some needs known but staff anticipated most of them. The resident had a diagnosis of dementia and needed | | **will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Activity Director/Designee will audit one on one activity residents for ongoing activities while in their rooms 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 months. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results.** | |

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| | assistance and cuing for activity programs. Due to COVID-19 precautions, the resident was provided with sensory stimulated activities on a 1 to 1 basis. The resident was praised for her efforts and participation. She would be encouraged to participate as she could tolerate.<br><br>The resident was provided stop in visits on 5/2, 5/3, 5/4, and 5/5/21.<br><br>Interview with the Activity Director on 5/5/21 at 11:50 a.m., indicated she was aware the resident needed ongoing activities during the day while in her room. She did provide 1 to 1 visits for the resident. The Activity Director indicated there were group activities currently being done in the facility due to no recent COVID-19 outbreaks.<br><br>3.1-33(a) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. | | | |
| | Based on observation, record review and interview, the facility failed to ensure areas of bruising were assessed and monitored for 3 of 4 residents reviewed for skin conditions (non-pressure related). (Residents 88, C, and 60). The facility also failed to ensure medications were initiated per Physician's Order for 1 of 5 residents reviewed for unnecessary medications. (Resident | F 0684 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 88 area of bruising assessed and documented, orders in place to monitor until healed, care plan updated. Resident C's | 05/28/2021 |

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| | 83)<br><br>Findings include:<br><br>1. On 4/30/21 at 10:07 a.m., Resident 88 was observed with a large area of yellow/purple discolorations to her left forearm. The resident also had a small area of reddish/purple discoloration to the top of her left hand near her thumb. She also had scattered areas of reddish/purple bruising to her right forearm.<br><br>Interview with the resident at that time, indicated she had a recent hospitalization and her forearm was bruised due to getting "stuck" for blood work.<br><br>On 5/3/21 at 9:55 a.m., 11:38 a.m., and 2:22 p.m., the resident was observed in her room in bed. The multiple areas of yellow/purple bruising to the left forearm remained as well as the areas of reddish/purple discoloration to the right forearm.<br><br>On 5/4/21 at 9:22 a.m., 10:55 a.m., and 1:10 p.m., the resident was observed in her room in bed. The multiple areas of yellow/purple bruising to the left forearm remained as well as the areas of reddish/purple discoloration to the right forearm.<br><br>On 5/5/21, at 1:53 p.m., the resident was observed with fading yellow/purple discoloration to the left forearm. A new area of dark purple discoloration was observed near the resident's left wrist. The resident's right forearm was wrapped in gauze.<br><br>The record for Resident 88 was reviewed on 5/4/21 at 8:16 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anemia, type 2 diabetes, chronic kidney disease, long term use of anticoagulants (blood thinners), | | areas of bruising assessed and documented. Orders in place to monitor until healed, care plan updated. Resident 60 areas of bruising with orders in place to monitor until healed, care plan reviewed. Resident 83 had iron study collected on 5/6/2021, results were received and were WNL. Lab results reviewed by physician, no new orders given.<br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>All residents have the potential to be affects. A skin sweep was completed on all residents, any residents noted with any new discolorations had the proper documentation updated and care plan updated. Labs/diagnostics ordered for past 30 days reviewed to insure that no new orders received that were not followed through on.<br>3. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice dose not recur:<br>Education was given to Licensed Nurses on Non-pressure skin condition and the process to be followed when areas are identified. Also provide education related to transcribing orders written by physician related to lab results.<br>4. How the corrective action will | |

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| | and stroke. The resident was readmitted to the facility on 4/23/21.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 4/2/21, indicated the resident had short and long term memory problems and was moderately impaired for daily decision making. The resident also needed extensive assistance with bed mobility and transfers.<br><br>A Physician's Order, dated 4/24/21, indicated the resident was to receive an 81 milligram (mg) Aspirin daily.<br><br>A Care Plan, dated 4/28/21, indicated the resident was at risk for complications related to routine aspirin use. Interventions included, but were not limited to, observe for signs and symptoms of bleeding, for example, tarry stools (blood in stool), blood in urine, bruising, and petechiae (brown-purple spots due to bleeding under the skin).<br><br>The readmission assessment, dated 4/23/21, indicated there was no documentation related to bruising.<br><br>Nurses' Notes, dated 4/27/21 at 1:06 p.m., indicated the resident's Warfarin (blood thinner) was on hold at the time due to significant anemia.<br><br>The resident's weekly skin review, dated 5/3/21, indicated there was no documentation related to bruising.<br><br>The April and May 2021 Treatment Administration Records (TAR) were reviewed. There was no documentation indicating the areas of discoloration were being monitored. | | be monitored to ensure the deficient practice will not recur: DON or designee will audit 6 randomly selected residents weekly checking for skin integrity and appropriate documentation/care plan x 4 weeks then 6 residents bi-monthly x 4 weeks then 6 residents monthly x 4 months. Lab results will be reviewed for new orders 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly x 4 months. The results of the audits will be reviewed quarterly in the QAPI meeting. The QAPI committee will determine the need for further auditing | |

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| | Interview with the B Wing Unit Manager on 5/5/21 at 2:00 p.m., indicated when a new bruise was noted, the nurse was to take measurements, assess the areas, and document on a new skin assessment form. The areas were to be monitored and documented on the TAR.2. On 5/4/21 at 1:00 p.m., Resident C arrived back from dialysis and was placed in the bed per the Emergency Medical Service (EMS) personnel. There was a bandage on her left upper arm covering her dialysis access site. There was a large dark red and purple bruise noted next to the bandage which wrapped around her underarm. There were areas of light red/yellow bruising noted as well on the left upper arm.<br><br>On 5/5/21 at 10:54 a.m., during a pressure ulcer treatment with the B Wing Unit Manager and the Nurse Consultant, the dark red and purple areas were observed.<br><br>Interview with both nurses at that time, indicated some of the areas looked to be old and some of them were new. The B Wing Unit Manager just noticed the areas on 5/5/21.<br><br>The record for Resident C was reviewed on 5/4/21 at 1:43 p.m. Diagnoses included, but were not limited to acute kidney failure, end stage renal disease, and type 2 diabetes.<br><br>The resident was admitted to the hospital on 3/22/21 and returned to the facility on 3/26/21. She had another hospital admission on 4/14/21 and returned on 4/19/21.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was understood and was able to understand with some modified cognitive ability. The resident | | | |

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needed extensive assist with 2 person physical assist for bed mobility, transfers, dressing and toilet use.

A Care Plan, updated 5/3/21, indicated the resident was at risk for complications related to routine
aspirin therapy. The approaches were to observe for signs and symptoms of bleeding like tarry stools, blood in urine, bruising, and petechiae.

The last weekly skin assessment, dated 4/26/21, indicated the resident had pre-exiting areas, no new open areas and no bruising noted.

A hospital readmission assessment, dated 4/19/21, indicated bruising was noted to the right wrist, right elbow, back of right hand, right bend of arm, and left bend of arm.

There was no follow up monitoring or assessment completed after the bruises were identified on 4/19/21.

The 4/2021 and 5/2021 Treatment Administration Records (TAR) indicated there was no monitoring of any bruising to both arms and hands.

Interview with the B Wing Unit Manager on 5/5/21 at 10:32 a.m., indicated when a new bruise was noted the nurse was to take measurements, assess the areas, and document on a new skin assessment form. The areas were to be monitored and documented on the TAR.

A skin assessment, dated 5/5/21 at 2:30 p.m., indicated the resident had new areas of bruising in addition to open areas previously noted to the right lateral thigh, right heel, and sacrum area. New areas of bruising to the left anecdotal space

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| | measured 9.0 centimeters (cm) by 20.0 cm and was purple in color. The bruise wrapped around to the posterior area of the arm. The right-posterior hand near the thumb measured 2.0 cm by 3.0 cm and was deep purple in color. The right wrist measured 5.0 cm by 4.0 cm.<br>3. On 5/4/21 at 4:18 p.m., interview with Resident 60 indicated she recently had a bad fall and hurt her knees. Observation at the time, indicated she had bilateral bruising to both of her knees.<br><br>The record for Resident 60 was reviewed on 5/4/21 at 11:11 a.m. Diagnoses included, but were not limited to, cellulitis, acute respiratory failure, diabetes, atrial fibrillation, major depression, and obstructive sleep apnea.<br><br>The Annual Minimum Data Set (MDS) assessment, dated 3/16/21, indicated the resident was alert and oriented and required supervision with transfers. Medications received during the 7 day look back period included, but were not limited to, anticoagulants.<br><br>A Physician's Order, dated 4/25/21, indicated monitor bruise to right and left knee until healed.<br><br>The Post Fall Evaluation, dated 4/21/21, indicated the resident had an unwitnessed fall in her bathroom and had a "light purple circular bruise approximately." There was no further documentation to indicate the size and location of the bruise.<br><br>A Nursing Note, dated 4/24/21 at 6:20 a.m., indicated upon rendering treatment for the resident the writer observed a large bluish purple bruising to the resident's left and right knees. The right knee measured 12 cm (centimeters) x (by) 12 cm and the left knee measured 6 cm x 8 cm. | | | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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Interview with the B Wing Unit Manager on 5/5/21 at 1:20 p.m., indicated the resident's bruising should have been properly assessed, documented, and monitored after the fall on 4/21/21.

The "Skin Integrity Guideline" policy provided by the Interim Director of Nursing on 5/5/21 at 4:30 p.m., indicated the residents should be evaluated/observed for risk of skin breakdown and existing areas including, but not limited to, bruising, skin tears, and wounds.4. Resident 83's record was reviewed on 5/3/21 at 9:58 a.m. Diagnoses included, but were not limited to, anemia, diabetes mellitus, high blood pressure and cardiorespiratory (heart and lung) conditions.

The Quarterly Minimum Data Set (MDS) assessment, dated 3/31/21, indicated the resident was cognitively intact and required assistance with activities of daily living.

An iron metabolism laboratory test, completed on 1/6/21, indicated the resident's iron levels were below normal. A note was written on the laboratory result sheet that read, "1/7/21, spoke with Dr. (name of doctor), new order for Ferrous Sulfate (iron supplement) 325 milligrams (mg) three times a day."

A change in condition note, dated 1/7/21 at 2:21 p.m., indicated the Physician was sent the current laboratory results and a new order was obtained for Ferrous Sulfate 325 mg, three times a day. The family and resident were notified of the change.

The January, February, March, April and May 2021 Medication Administration Records (MARs) indicated there was no order for the Ferrous

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| | Sulfate and no documentation the medication had been initiated on 1/7/21.<br><br>Interview with the Interim Director of Nursing on 5/6/21 at 1:14 p.m., indicated the nurse that received the Physician's Order should have put the order in the computer and faxed the order to the pharmacy.<br><br>3.1-37(a) | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to ensuring treatments were completed as recommended by the Wound Physician for 2 of 6 residents reviewed for pressure ulcers. (Residents C and D)<br><br>Findings include: | F 0686 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident C's treatment orders were clarified. Wounds have been showing improvement in status. Resident D no longer resides at facility.<br>2.How other residents having the potential to be affected by the | 05/28/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | 1. On 5/5/21 at 10:54 a.m., Resident C was observed in bed. At that time, the B Wing Unit Manager and the Nurse Consultant were going to change the resident's bandages on her pressure ulcer. The bandages were removed from the resident's buttocks. The resident had a large pressure ulcer on her buttocks with slough (necrotic tissue) and granulation (healthy tissue).<br><br>The record for Resident C was reviewed on 5/4/21 at 1:43 p.m. Diagnoses included, but were not limited to acute kidney failure, end stage renal disease, type 2 diabetes, obesity, congestive heart failure, and high blood pressure.<br><br>The resident was admitted to the hospital on 3/22/21 and returned to the facility on 3/26/21. She had another hospital admission on 4/14/21 and returned on 4/19/21.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was understood and was able to understand with some modified cognitive ability. The resident needed extensive assist with 2 person physical assist for bed mobility, transfers, dressing and toilet use. The resident had 2 unstageable pressure ulcers that were present on admission.<br><br>A Care Plan, updated 5/3/21, indicated the resident had an actual pressure ulcer to the right and left coccyx/buttocks and right heel. The approaches were to conduct weekly skin inspections, weekly wound assessments, and provide treatments as ordered.<br><br>Nurses' Notes, dated 4/10/21 at 5:39 p.m., indicated the resident was noted to have multiple areas of impairment including pressure ulcers to the left and right buttocks area. The resident also | | same deficient practice will be identified and what corrective action will be taken:<br>Whole house audit on pressure ulcer treatment orders and administrations were completed and no other residents were identified.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Licensed Nurse's education on discontinuing previous orders when a new order is obtained. Also educated on the importance of completing all scheduled treatments and documenting their completion directly after completion.<br>4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or designee will review any new treatment orders to insure that previous order has been discontinued three times per week x 4 weeks, two times per week x 4 weeks then weekly x 4 months. Director of Nursing or designee will audit treatment records three times weekly x 4 weeks, two times per week x 4 weeks then weekly x 4 months. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. | |

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| | had deep tissue injuries to the left and right heels.<br><br>Physician's Orders, dated 4/10/21, indicated Medihoney (a debriding agent) apply to the right and left buttocks wound every evening shift and cover with a foam dressing.<br><br>The 4/2021 Treatment Administration Record (TAR), indicated the Medihoney was not signed out as being completed on 4/10 and 4/11/21.<br><br>A Braden scale assessment, dated 4/19/21, indicated the resident was at risk for developing pressure ulcers.<br><br>A skin-only readmission assessment/evaluation, dated 4/19/21 at 9:50 p.m., indicated the resident had a pressure ulcer to the left buttock. The wound was unstageable and measured 3.2 centimeters (cm) by 1.5 cm with slough noted. The resident had another ulcer to the right buttock. The wound was unstageable and measured 8.5 cm by 2.4 cm. The ulcer was covered with slough.<br><br>Physician's Orders, dated 4/19/21, indicated Santyl Ointment (a debriding agent) 250 units/gram: Apply to buttocks area topically every day and evening shift for pressure ulcers. Cleanse with normal saline, pat dry, and apply Santyl to wet gauze and cover with dry gauze and abd pad.<br><br>The Wound Physician Progress Notes, dated 4/27/21, indicated the resident was observed with a Stage 4 pressure ulcer to the coccyx. The wound measured 6.1 cm by 4.3 cm by 1 cm. The wound had thick adherent devitalized necrotic tissue, slough, and granulation tissue. The treatment plan was to apply Dakin's solution once daily for 30 days, followed by a normal saline | | Modifications of frequency may be adjusted based on results. | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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rinse. Santyl was to be applied once daily for 30 days and Alginate Calcium was also to be applied once daily for 30 days.

Physician's Orders, dated 4/27/21, indicated Dakin's (1/2 strength) Solution 0.25 % (Sodium Hypochlorite) apply to coccyx topically one time a day for wound cleansing. Cleanse with Dakin's, rinse with normal saline and apply Santyl on moistened Calcium Alginate dressing, and cover with gauze with border.

The 4/2021 Medication Administration Record (MAR), indicated the Dakin's solution was not applied on 4/28 due to it was refused by the resident and 4/29/21 due to the resident being LOA (leave of absence).

The 5/2021 MAR, indicated the Dakin's was signed out as being completed on 5/1 and 5/2/21.

The TAR for 4/2021, indicated the Santyl continued to be signed out as being administered every day and evening shift on 4/27- 4/30/21 after the new Physician's Orders for the Dakin's solution had been written.

The 5/2021 TAR indicated the Santyl was signed out as being administered every day and evening shifts on 5/1-5/3.

Interview with the Nurse Consultant on 5/5/21 at 11:20 a.m., indicated she had called the Wound Physician herself on 5/4/21 and clarified the order. The resident was not supposed to be receiving treatments of Santyl two times a day. The Dakin's solution was discontinued and the Calcium Alginate was to be administered along with the Santyl.

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | 2. The record for Resident D was reviewed on 5/3/21 at 10:10 a.m. Diagnoses included, but were not limited to, kidney failure, sepsis, pneumonia, type 2 diabetes, obesity, anemia, peripheral vascular disease, high blood pressure, and major depression.<br><br>The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 4/6/21, indicated the resident was able to understand and was understood. The resident had an unhealed pressure ulcer which was a Stage 4 and was not present on admission. No necrotic tissue was noted.<br><br>The Care Plan, updated 2/22/21, indicated the resident had a pressure ulcer above the right outer ankle.<br><br>The Wound Physician Progress Notes, dated 4/6/21, indicated a Stage 4 pressure ulcer to the right lateral ankle. The wound measured 8 centimeters (cm) by 3.8 cm by 0.2 cm. There was 70% granulation tissue and 30% of other viable tissues. The wound had deteriorated and a new treatment plan was to be initiated. Alginate Calcium was to be applied once daily for 30 days.<br><br>Physician's Orders, dated 3/30/21, indicated Santyl Ointment (a debriding agent) 250 unit/grams apply to the right outer ankle topically every evening shift for skin impairment and cover with a foam dressing.<br><br>There was no Physician's Orders for the Alginate Calcium to be applied to the right outer ankle for 30 days.<br><br>A weekly skin measurement of the right ankle, dated 4/27/21, indicated the right ankle was a | | | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | Stage 4 wound that measured 6 cm by 2.8 cm by 0.1 cm. The wound bed was 100% granulation.<br><br>The last skin measurement was on 5/4/21. The right ankle was a Stage 4 wound that measured 5.8 cm by 4.0 cm by 0.1 cm and was 100% granulation tissue.<br><br>The Medication Administration Record (MAR) for the months of 3/2021, 4/2021 and 5/2021 up until 5/4/21 indicated the resident's right ankle pressure ulcer was treated with the Santyl ointment.<br><br>Interview with the C Wing Unit Manager on 5/4/21 at 2:15 p.m., indicated the floor nurses were doing rounds with the Wound Physician, however, the Assistant Director of Nursing took over and some orders had not been carried out.<br><br>Interview with the Interim Director of Nursing on 5/5/21 at 8:30 a.m., indicated the treatment orders were not correct and were not current to what the Wound Physician had ordered.<br><br>This Federal tag relates to Complaint IN00347399.<br><br>3.1-40(a)(2) | | | |
| F 0688<br>SS=D<br>Bldg. 00 | 483.25(c)(1)-(3)<br>Increase/Prevent Decrease in ROM/Mobility<br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of | | | |

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| | motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>Based on observation, record review, and interview, the facility failed to ensure a resident with limited range of motion received the necessary treatment and services to maintain mobility related to the completion of a seat belt assessment for positioning and splints not documented as being placed for 1 of 2 residents reviewed for limited range of motion. (Resident F)<br><br>Finding includes:<br><br>On 4/30/21 at 9:04 a.m., Resident F was observed with contractures to both of her hands. At that time, she indicated she had an electric wheelchair for mobility, which had a seat belt built into the chair.<br><br>On 5/3/21 at 11:38 a.m., the resident was observed in her electric wheelchair. The seat belt was fastened around her waist. Interview with the resident at that time, indicated she had to wear the seat belt while in the chair due to being a quadriplegic and she leaned forward. She stated, "It's not a restraint." The splints were donned every night and removed by 5:00 a.m., every morning. The resident indicated she used to be a CNA so she was very familiar with everything and what needed to be done with her care.<br><br>The record for Resident F was reviewed on 5/4/21 | F 0688 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident F had appropriate assessments completed related to seatbelt and it was determined that it was an enabler that aided in maintaining safe seating in motorized wheelchair and increased resident's independence in locomotion and socialization. Her hand splints were being applied and removed per orders and order updated to include signature for donning and doffing.<br>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Facility wide audit done to identify any other residents. Residents identified have had appropriate assessments completed and orders in place for donning and doffing devices.<br>3.What measures will be put into place and what systemic changes will be made to ensure | 05/28/2021 |

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| | at 9:25 a.m. Diagnoses included, but were not limited to, quadriplegia (paralysis), hemiplegia (muscle weakness), cord compression, major depressive disorder, and anxiety.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/21, indicated the resident was alert and oriented. She needed extensive assist with a 2 person physical assist for bed mobility, transfers, and dressing. She had impairment in range of motion to both upper and lower extremities. The resident used a wheelchair for mobility.<br><br>The Care Plan, updated on 3/26/21, indicated the resident had a physical functioning deficit related to range of motion limitations due to quadriplegia and spastic hemiplegia. The approaches were to have splints as ordered.<br><br>There was no Care Plan for the seat belt.<br><br>Physician's Orders, dated 1/12/21, indicated bilateral upper extremity splints were to be worn at night time and removed in the morning.<br><br>There was no Physician's Order for the seat belt to be utilized in the electric wheelchair.<br><br>There was no seat belt assessment to indicate it was to be used for positioning to prevent the resident from leaning forward in the electric wheelchair.<br><br>There was no documentation of donning and doffing the upper extremity hand splints.<br><br>Interview with the C Wing Unit Manager on 5/4/21 at 2:15 p.m., indicated there was no documentation of donning and doffing the | | that the deficient practice does not recur:<br>Education provided to Nursing staff related to the need to complete appropriate assessments, have orders for donning and doffing of devices that include signing them off and care plan in place.<br>Devices to be included on care guide.<br>4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Restorative Nurse or designee will audit for orders in place and being signed for donning and doffing and restraints assessments quarterly for 5 residents three times per week x 4 weeks, then 5 residents two times per week x 4 weeks, then 5 residents per week weekly x 4 months. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |

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| | splints. She indicated they had not had a restorative program in place for a while. There was no assessment, Care Plan, or order for the seat belt. The seat belt was not used as a restraint, it was for positioning in the electric wheelchair. She indicated the resident did keep them on their toes and she would let the staff know when something was not right.<br><br>Interview with the Interim Executive Director and Interim Director of Nursing on 5/5/21 at 8:35 a.m., indicated the resident could release the seat belt with an ink pen and they were not calling it a restraint due to it could be released and it was used as an enabler. A Care Plan and an assessment of the seat belt was then completed on 5/4/21 after the fact.<br><br>3.1-42(a)(2) | | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review and interview, the facility failed to ensure fall interventions were in place for a resident with a history of falls for 1 of 4 residents reviewed for falls. (Resident 72)<br><br>Finding includes: | F 0689 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 72's care plan reviewed and updated to include pertinent fall prevention interventions. Care guide updated as well. | 05/28/2021 |

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| | On 4/30/21 at 10:18 a.m., Resident 72 was observed in his room seated in his wheelchair. He was dressed in his street clothes with no shoes on his feet. The resident was wearing socks that did not have a non-skid surface.<br><br>On 5/3/21 at 9:33 a.m., 12:40 p.m., and 2:15 p.m., the resident was observed in bed, no floor mat was noted.<br><br>On 5/4/21 at 12:50 p.m. and 2:24 p.m., the resident was observed in bed, no floor mat was noted.<br><br>On 5/5/21 at 9:22 a.m., the resident was observed in bed, no floor mat was noted.<br><br>The record for Resident 72 was reviewed on 5/3/21 at 9:58 a.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia, chronic obstructive pulmonary disease and hypertension.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/17/21, indicated the resident was severely cognitively impaired for decision making and required a physical 2 person assist with bed mobility, transfers, and personal hygiene.<br><br>A revised Care Plan, dated 5/3/21, indicated the resident was at risk for falls. The interventions included, but were not limited to, non skid strips next to the bed and a floor mat at the bedside while in bed.<br><br>There were no observations of the above interventions at the resident's bedside.<br><br>Interview with the B Wing Unit Manager on 5/5/21 at 1:20 p.m., indicated the resident has not | | 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Residents with a history of falls care plans reviewed and updated as needed to include pertinent interventions. Care guides updated as needed.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Nursing staff and Interdisciplinary team educated on the importance of insuring that new interventions are in place on care plan and care guide as well as removing interventions that are no longer appropriate.<br>4.How the corrective action will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place:<br>Director of Nursing or designee will review 3 residents fall care plans and care guide for appropriateness 3 times a week x 4 weeks, 3 residents two times a week x 4 weeks, then 3 residents a week for 4 months. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |

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| | 155187 | A. BUILDING 00<br>B. WING | 05/06/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | had any recent falls.<br><br>3.1-45(a)(2) | | | |
| F 0690<br>SS=D<br>Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel | | | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | function as possible.<br>Based on record review and interview, the facility failed to follow Physician's Orders related to obtaining a urinalysis for 1 of 4 residents reviewed for urinary tract infections. (Resident 39)<br><br>Finding includes:<br><br>The record for Resident 39 was reviewed on 5/3/21 at 11:56 a.m. Diagnoses included, but were not limited to, cardiovascular disease, dementia, kidney failure, hypertension, foley catheter, and pressure ulcers.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/2/21, indicated the resident was never/rarely understood, and she required an extensive 2 person physical assist with bed mobility and transfers.<br><br>A Physician's Order, dated 4/29/21, indicated a urinalysis was to be obtained.<br><br>There was no documentation to indicate the urine sample was colleted and sent to the lab.<br><br>Interview with the Interim Director of Nursing on 5/5/21 at 10:15 a.m., indicated the urine sample was collected on 5/4/21 and sent out to the lab today. The Physician's Order should have been followed as ordered.<br><br>3.1-41(a)(2) | F 0690 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 39 had UA collected. Results received and physician and family notified of the results.<br>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Review of UAs ordered for past 30 days reviewed to insure completed timely. No other concerns identified.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Licensed Nurses provided with education in regard to the need to collect UA specimens per orders in a timely manner.<br>4.How the corrective action will be monitored to ensure the deficiency will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or designee will audit lab orders and check for completion three times per week x 4 weeks, then two times per week x 4 weeks then weekly x 4 months. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. | 05/28/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | | | Modifications of frequency may be adjusted based on results. | |
| F 0692<br>SS=D<br>Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure a resident's fluid intake was monitored while on a fluid restriction for 1 of 3 residents reviewed for nutrition. (Resident E)<br><br>Finding includes:<br><br>On 4/29/21 at 12:30 p.m., Resident E was served her lunch meal. The tray card indicated the resident was on a fluid restriction. She was served 120 cubic centimeters (cc's) of juice and there was a full large styrofoam cup of water on | F 0692 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident E's orders have been updated to include recording of fluid intake every shift.<br>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Audit of residents that have fluid | 05/28/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | the over bed table.<br><br>On 5/3/21 at 12:27 p.m., CNA 3 brought in the resident's lunch tray. She received 120 cc's of juice and a mechanical soft diet.<br><br>On 5/4/21 at 9:09 a.m., the resident was observed in bed. There was a 6 ounce cup of lemonade and a full large styrofoam cup of ice water on her over bed table.<br><br>On 5/4/21 at 2:00 p.m., the large styrofoam cup of water was still observed on the over table.<br><br>The record for Resident E was reviewed on 5/3/21 at 11:35 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia (muscle weakness), dysphagia (difficulty swallowing), chronic kidney disease, high blood pressure, and dementia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 2/17/21, indicated the resident was not alert and oriented. Her weight was 142 pounds with a significant weight loss noted. The resident received a mechanically altered and therapeutic diet.<br><br>A Care Plan, updated 2/19/21, indicated the resident received a therapeutic and mechanically altered diet with fluid restrictions related to chronic kidney disease. The approaches were to provide a fluid restriction as ordered and monitor food intake.<br><br>A Care Plan, updated 2/19/21, indicated the resident had a potential for alteration in hydration related to being on a fluid restriction. The approaches were to maintain the fluid restriction per physician order and monitor intake and output if indicated. | | restrictions completed, orders include documenting the amount of fluid intake each shift.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Nursing staff provided with education related to recording the fluid intake each shift for residents that have fluid restrictions as well as not leaving a cup of fluids at bedside.<br>4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or Designee will audit fluid intake MAR for fluid restriction residents three times per week x 4 weeks, then two times per week x 4 weeks then weekly x 4 months. Audits will be submitted to QAPI monthly with percentage of compliance. Modifications of frequency may be adjusted based on results. | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | A Registered Dietitian (RD) Progress Note, dated 2/17/21, indicated the resident had a significant weight loss and had decreased protein related to chronic kidney disease stage 4. She recommended liberalizing the fluid restriction to less than 2000 milliliters (ml), with a fluid breakdown of 330 ml every meal for dietary and 330 ml every shift for nursing.<br><br>Physician's Orders, dated 2/23/21, indicated fluid restriction 2000 ml daily: 330 ml dietary and 330 ml nursing every shift not to include supplements.<br><br>The Medication Administration Record (MAR) for the months of 4/2021 and 5/2021 indicated there were only checkmarks in the box for the fluid restriction. There was no documentation of how much fluid the resident consumed per shift.<br><br>There was no documentation in the meal intake record to indicate how much fluid the resident consumed at each meal.<br><br>Interview with the C Wing Unit Manager on 5/4/21 at 2:15 p.m., indicated nurses were only putting a check mark in the box and there was no accurate intake recorded of the amount of fluids the resident was receiving. There was also no documentation of the resident's intake or of the resident's fluids in the meal consumption logs.<br><br>Interview with the Interim Director of Nursing and the Interim Executive Director on 5/5/21 at 8:35 a.m., indicated there was no documentation of the breakdown of the fluid restriction. The resident should not have had the water at the bedside.<br><br>This Federal tag relates to Complaint IN00347399. | | | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | 3.1-46(b) | | | |
| F 0693<br>SS=D<br>Bldg. 00 | 483.25(g)(4)(5)<br>Tube Feeding Mgmt/Restore Eating Skills<br>§483.25(g)(4)-(5) Enteral Nutrition<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube (a feeding tube in the resident's abdomen) medications were administered following professional standards for 1 of 1 gastrostomy tube medication observations. (Resident 39)<br><br>Finding includes:<br><br>On 5/3/21 at 3:54 p.m., LPN 4 prepared, crushed and placed in cup, a Memantine (a medication used to treat the symptoms of Alzheimer's disease) 5 milligrams (mg) tablet for Resident 39. | F 0693 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 39 is without any adverse effect from placement not being checked. QMA was provided with education immediately and competency for G-tube placement check completed.<br>2.How other resident shaving the potential to be affected by the | 05/28/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | The LPN indicated the resident received her medications by the way of a gastrostomy tube (g-tube).<br><br>The LPN proceeded to the resident's room and administered the medication via the g-tube. The LPN did not check for g-tube placement prior to giving the medication.<br><br>Interview with LPN 4, on 5/3/21 at 4:00 p.m., indicated she was nervous and did not take her stethoscope in the resident's room to check for placement of the g-tube prior to administering her medication.<br><br>Resident 39's record was reviewed on 5/3/21 at 4:05 p.m. Diagnoses included, but were not limited to, non traumatic brain dysfunction and dementia.<br><br>The May 2021 Physician's Order Summary (POS), indicated to check for bowel sounds, abdominal distention, and peg tube placement.<br><br>The facility policy and procedure titled, "Medication Administration via Enteral Tube," was provided on 5/3/21 at 4:15 p.m. by the Interim Director of Nursing (DON). The current policy indicated, "Policy...9. Procedure h. Enteral tube placement must be verified prior to administering any fluids or medication...."<br><br>Interview with the Interim DON on 5/3/21 at 4:20 p.m., indicated the nurse should have verified placement by either checking for residual or with an air bolus and stethoscope prior to the administration of the medication.<br><br>3.1-44(a)(2) | | same deficient practice will be identified and what corrective action will be taken:<br>Residents that receive their medication via feeding tube have the potential to be affected. No other residents identified.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Licensed Nurses and QMAS have been provided with education related to checking feeding tube placement prior to administration of medications.<br>4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or designee will observe placement being administered via feeding tube three times per week x 4 weeks, then two times per week x 4 weeks, then weekly x 4 months. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |

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| F 0695<br>SS=E<br>Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. | | | |
| | Based on observation, record review, and interview, the facility failed to provide proper respiratory care and services related to oxygen at the correct flow rate and connected to the concentrator, having orders for oxygen and monitoring of humidification bottles for 5 of 5 residents reviewed for oxygen. (Residents 16, C, 58, 81, and 83)<br><br>Findings include:<br><br>1. On 4/29/21 at 8:55 a.m., Resident 16 was observed seated in a broda chair in her room. The resident was connected to a portable oxygen tank and it was set at 3 liters. At 2:44 p.m., the resident was connected to the oxygen concentrator and the rate was at 3 liters.<br><br>On 5/3/21 at 9:55 a.m. and 10:45 a.m., the resident was observed connected to the oxygen concentrator in her room. It was set at 3 liters.<br><br>The record for Resident 16 was reviewed on 5/3/21 at 2:45 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), dementia, chronic respiratory failure, major depressive disorder, and anxiety. | F 0695 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>Resident 16's, 58's and 83's oxygen adjusted to correct rate, resident without any adverse effects related to incorrect settings.<br>Resident C had her oxygen applied as per order. Resident without any adverse effects from not having oxygen in place correctly.<br>Resident 81's humidifier replaced and the oxygen rate was adjusted to correct setting. Resident without any adverse effects.<br>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>All residents that use oxygen have the potential to be effected, no other residents identified.<br>3.What measures will be put | 05/28/2021 |

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| | The Significant Change Minimum Data Set (MDS) assessment, dated 2/9/21, indicated the resident rarely understood and was severely impaired for decision making. She needed extensive assist with a 2 person physical assist with bed mobility, transfers, dressing, and personal hygiene. The resident received oxygen.<br><br>A Care Plan, dated 4/5/19, indicated the resident had an alteration in respiratory status due to chronic respiratory failure. The approaches were to administer oxygen per the physician order and monitor oxygen flow rate and response.<br><br>Physician's Orders, dated 4/4/19, indicated oxygen at 2 liters per nasal cannula every shift.<br><br>Interview with the Interim Director of Nursing on 5/5/21 at 8:30 a.m., indicated the resident's oxygen should have been at the correct flow rate as per the physician's order.<br><br>2. On 4/29/21 at 1:25 p.m., Resident C was observed in bed. At that time, her oxygen was on at 4 liters per minute. The nasal cannula was around her chin and not in the nose.<br><br>On 5/4/21 at 1:00 p.m., the resident arrived back from dialysis and was placed in the bed per the Emergency Medical Service (EMS) personnel. The resident was observed with a nasal cannula in her nose. The EMS did not hook the resident's oxygen up to the concentrator in the room. The oxygen concentrator in the room was set at 4 liters per minute. After the EMS personnel left the room, LPN 1 entered and repositioned the resident, however she did not hook up the resident's oxygen. | | into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Nursing staff have been provided with education related to insuring that resident's oxygen is set at the correct rate and that humidifier bottles are not empty.<br>4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or designee will audit 5 residents 3 times per week x 4 weeks, then 2 times per week x 4 weeks and then weekly x 4 months. | |

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| | On 5/4/21 at 1:55 p.m., the resident was observed in bed and eating her lunch. The resident's oxygen was not connected to the concentrator, however, the nasal cannula was in her nose.<br><br>The record for Resident C was reviewed on 5/4/21 at 1:43 p.m. Diagnoses included, but were not limited to obesity, chronic obstructive pulmonary disease (COPD), asthma, congestive heart failure, high blood pressure, and sleep apnea.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was understood and was able to understand with some modified cognitive ability. The resident needed extensive assist with 2 person physical assist for bed mobility, transfers, dressing and toilet use. She received oxygen while at the facility.<br><br>A Care Plan, dated 12/1/14, indicated the resident had an alteration in respiratory status due to asthma and COPD. The resident had voiced complaints of shortness of breath at rest, when lying flat, and upon exertion. The approaches were to administer oxygen as needed per physician order. Monitor oxygen flow rate and response.<br><br>Physician's Orders, dated 4/19/21, indicated oxygen at 2 liters per nasal cannula.<br><br>Interview with the Interim Director of Nursing on 5/5/21 at 8:35 a.m., indicated the resident should have had her oxygen hooked up when she came back from dialysis and on at the correct flow rate.3. On 4/30/21 at 11:10 a.m., Resident 58 was observed to have oxygen via nasal cannula in use. The oxygen concentrator was set at 3 liters per minute. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155187 | A. BUILDING 00<br>B. WING | 05/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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On 5/3/21 at 9:21 a.m., LPN 2 was observed removing the oxygen concentrator from the resident's room. Interview with the LPN at that time, indicated she removed the oxygen concentrator due to the facility did not have an order for it.

Resident 58's record was reviewed on 5/3/21 at 9:04 a.m. Diagnoses included, but were not limited to, dementia and chronic obstructive pulmonary disease (difficulty breathing).

A Clinical Admission Evaluation Nursing Note, dated 4/27/21 at 9:21 p.m., indicated the resident had utilized oxygen and the flow rate was set at 4 liters per minute via the nasal cannula.

The record lacked a Physician's Order for the oxygen.

Interview with LPN 1, on 5/4/21 at 9:15 a.m., indicated the nurse on duty would review the admitting orders from the hospital and verify the orders with the Physician.

4. On 4/29/21 at 9:35 a.m., Resident 81's humidifier water bottle on her oxygen concentrator was observed to have been dated "4/25" and was empty. Her oxygen flow rate was set at 3.5 lpm (liters per minute).

On 5/3/21 at 9:31 a.m., the resident's humidifier water bottle on her oxygen concentrator was observed to have been dated "5/3" and was now full. Her oxygen flow rate was set at 3.5 lpm.

On 5/4/21 at 11:28 a.m., the resident's oxygen flow rate was observed to have been set between 3.5 lpm and 4 lpm.

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| | 155187 | A. BUILDING 00<br>B. WING | 05/06/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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Resident 81's record was reviewed on 5/3/21 at 9:08 a.m. Diagnoses included, but were not limited to, chronic lung disease, heart failure and morbid obesity.

The Annual Minimum Data Set (MDS) assessment, dated 3/29/21, indicated the resident was totally dependent on the staff for transfers and was an extensive, two person assist with bed mobility.

The May 2021 Physician's Order Summary (POS) indicated, to change the oxygen tubing and equipment on Sundays and the oxygen flow rate was to be set at 3 lpm.

The May 2021 Treatment Administration Record (TAR) indicated, the humidifier water bottle was changed on 5/2/21 by a nurses's initials.

A Care Plan for "Alteration in Respiratory Status," revised on 4/29/21, indicated an intervention, revised on 3/19/21, was to administer oxygen per the Physician's Order.

Interview and observation with LPN 3, on 5/4/21 at 11:37 a.m., indicated the oxygen flow rate was set at 4 lpm, she verified the physician orders and the flow rate should have been set at 3 lpm. She indicated nurses and Guardian Angels should have been monitoring the concentrators flow rate.

5. On 4/29/21 at 9:58 a.m., Resident 83's oxygen flow rate was observed at 5 lpm (liters per minute). Interview with the resident at that time, indicated she was supposed to have oxygen on at 4 lpm.

On 5/3/21 at 9:27 a.m., Resident 83's oxygen flow rate was observed at 5 lpm.

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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Resident 83's record was reviewed on 5/3/21 at 9:58 a.m. Diagnoses included, but were not limited to, anemia, diabetes mellitus, high blood pressure and cardiorespiratory (heart and lung) conditions.

The Quarterly Minimum Data Set (MDS) assessment, dated 3/31/21, indicated she was cognitively intact for daily decision making, needed limited one person assist with bed mobility and was on oxygen therapy.

The current Physician Order Summary indicated the oxygen flow rate was to be set at 4 lpm continuously via nasal cannula every shift.

The April and May 2021 Medication Administration Records, indicated the oxygen flow rate was checked by a nurse every shift.

A Care Plan titled "Alteration in Respiratory Status," dated 1/21/20, indicated an intervention was to administer oxygen as needed per the Physician's Order.

Interview and observation with LPN 3, on 5/3/21 at 10:33 a.m., indicated the resident's oxygen flow rate was set at 5 lpm and verified the physician's order was to have been set at 4 lpm. The nurse and Guardian Angel completed rounds and should verify the oxygen flow rate with the resident's care card.

Interview with the Activities Director, the resident's Guardian Angel, on 5/3/21 at 10:39 a.m., indicated rounding was completed a couple of times a day to check in on the resident and the resident's information was on the care card. She indicated the resident's oxygen flow rate was missed today.

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| | 155187 | A. BUILDING 00<br>B. WING | 05/06/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | 3.1-47(a)(6) | | | |
| F 0697<br>SS=D<br>Bldg. 00 | 483.25(k)<br>Pain Management<br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on record review and interview, the facility failed to ensure a resident with complaints of pain received as needed (prn) or scheduled medication to relieve the pain for 1 of 5 residents reviewed for pain. (Resident C)<br><br>Finding includes:<br><br>During an interview with Resident C on 4/29/21 at 1:18 p.m., the resident indicated she had pain all over, and had an ulcer on the buttocks. The resident indicated her pain was a 10 out of 10 currently and she had asked for something, but no one had come back.<br><br>The record for Resident C was reviewed on 5/4/21 at 1:43 p.m. Diagnoses included, but were not limited to rheumatoid arthritis, acute kidney failure, end stage renal disease, type 2 diabetes, obesity, congestive heart failure, high blood pressure, sleep apnea, cellulitis of the right lower limbs, osteoarthritis, and pain.<br><br>The resident was admitted to the hospital on 3/22/21 and returned to the facility on 3/26/21. She had another hospital admission on 4/14/21 and returned on 4/19/21. | F 0697 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident C is receiving her pain medication as needed when she reports pain.<br>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Residents with prn pain medication have been reviewed to insure that they are having complaints of pain addressed.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Licensed Nurses and QMAS have been provided with education in regard to monitoring for complaints and non-verbal signs of pain and to administer PRN pain medications when pain is identified or reported by the resident. | 05/28/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | The Significant Change Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was understood and was able to understand with some modified cognitive ability. The resident needed extensive assist with 2 person physical assist for bed mobility, transfers, dressing and toilet use. The resident had no scheduled pain medication, but had a (prn) as needed pain medication. The resident's pain was almost constant in the last 5 days. Her pain was rated a 4 out of 10. The resident had 2 unstageable pressure ulcers that were present on admission. She received oxygen while at the facility.<br><br>A Care Plan, updated 5/3/21, indicated the resident needed pain management and monitoring related to osteoarthritis. The approaches were to will maintain adequate level of comfort as evidenced by no signs or symptoms of unrelieved pain or distress. Will achieve an acceptable pain level goal and<br>administer pain medication as ordered. Evaluate need to provide medications prior to treatment or therapy and evaluate what makes the patient's pain worse.<br><br>A pain assessment, dated 4/19/21, indicated the resident voiced complaints of pain on her buttocks. Her pain level was a 5 out of 10. Her pain was aching and limited her activity. Dressing changes made the pain worse and repositioning helped. Wounds to the bilateral buttocks were painful.<br><br>Physician's Orders, dated 4/10/21 and discontinued on 4/14/21, indicated Norco (Hydrocodone a narcotic pain medication) tablet 7.5-325 milligrams (mg) give 0.5 tablet by mouth every 8 hours as needed for pain. | | 4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or designee will interview 3 residents about pain levels three times per week x 4 weeks, then two times per week for 4 weeks, then weekly x 4 months. Pain will be addressed as reported. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |

Physician's Orders, dated 4/21/21, indicated Norco (Hydrocodone a narcotic pain medication) tablet 7.5-325 milligrams (mg) give 0.5 tablet by mouth every 8 hours as needed for pain.

Nurses' Notes, dated 4/10/21 at 5:39 p.m., indicated the resident was noted to have multiple areas of impairment including pressure ulcers to the left and right buttocks area. The resident also had deep tissue injuries to the left and right heels.

Physician's Orders, dated 4/10/21 indicated Medihoney (a debriding agent) to the right and left buttocks daily and cover with a foam dressing.

The Medication Administration Record (MAR) for 4/2021 indicated the Norco was signed out one time a day as being administered on 4/10, 4/11, and 4/13/21.

Physician's Orders, dated 4/19/21, indicated Santyl Ointment (a debriding agent) 250 units/gram: Apply to buttocks area topically every day and evening shift for pressure ulcers. Cleanse with normal saline, apply Santyl and cover with dry gauze sponge.

The 4/2021 MAR, indicated there was no pain medication administered on 4/19, 4/20, 4/21, 4/24, 4/28, and 4/29/21 prior to the pressure ulcer treatments. The resident received only 1 pain pill on 4/23, 4/25, 4/27, and 4/30/21.

The 5/2021 MAR, indicated the resident did not receive any pain medication on 5/1 and 5/3/21. The resident received only one pain pill on 5/2 and 5/4/21.

Interview with the B Wing Unit Manager on 5/5/21 at 10:30 a.m., indicated the resident was

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | receiving Norco on a regular scheduled basis for a long time, prior to her pressure sores. She indicated after she came back from the hospital on 4/19/21 she had no pain medication ordered. The resident was readmitted on the C Wing due to the need to be in transmission based precautions.<br>The B Wing Unit Manager contacted the resident's physician to obtain pain medication for the resident while on the other unit. The resident was able to get a pain pill at least 3 times a day and she only received the pain medication either one or two times a day while on the other unit.<br>The Unit Manager was aware the resident was in a lot of pain due to the pressure ulcers, therefore she was going to make sure she was pre-medicated before treatment.<br><br>3.1-37(a) | | | |
| F 0698<br>SS=D<br>Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on record review and interview, the facility failed to provide the necessary care and services for residents who received Hemodialysis related to not assessing nor monitoring the access site for 1 of 1 residents reviewed for dialysis. (Resident 6)<br><br>Finding includes:<br><br>The record for Resident 6 was reviewed on 5/3/21 at 11:10 a.m. Diagnoses included, but were not limited to, end stage renal disease and urinary | F 0698 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 6 is without adverse effects from missed fistula assessments.<br>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: | 05/28/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | retention.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 2/3/21, indicated the resident was cognitively intact for daily decision making and received dialysis.<br><br>The April 2021 Physician's Order Summary (POS), indicated the resident's dialysis access site was to be assessed every shift for placement, signs and symptoms of infection, bleeding, or any other complications.<br><br>The Care Plan, dated 12/9/20 and reviewed 2/2021, indicated the resident had an alteration in kidney function due to end stage renal disease and dialysis. Interventions included, but were not limited to, check access site catheter for signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, and body chills).<br><br>The March 2021 Treatment Administration Record (TAR), indicated the resident's access site was not monitored each shift on the following dates:<br><br>Day shift: 3/10/21<br><br>Evening shift: 3/10 and 3/29/21<br><br>Night shift: 3/7, 3/11, and 3/16/21<br><br>The April 2021 TAR, indicated the resident's access site was not monitored each shift on the following dates:<br><br>Evening shift: 4/21, 4/22, 4/26, and 4/28/21<br><br>Night shift: 4/19, 4/20, and 4/22/21<br><br>Interview with the Interim Director of Nursing on | | Residents with fistulas that are on dialysis were reviewed to identify any others that may have had missed assessed. No adverse effects were identified.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Licensed Nurses provided with education related to the need to complete the assessment of dialysis access site daily and document on the TAR.<br>4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or designee will audit 5 dialysis resident's TARS for assessment of dialysis access site three times per week x 4 weeks then two times weekly x4 weeks, then weekly x 4 months. Discrepancies will be addressed at the time noted. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | 5/5/21 at 9:00 a.m., indicated the resident's fistula should have been monitored every shift as ordered.<br><br>3.1-37(a) | | | |
| F 0757<br>SS=D<br>Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. | | | |
| | Based on record review and interview, the facility failed to ensure insulin was held per parameters and anticoagulant (blood thinner) medications were monitored for side effects for 2 of 5 residents reviewed for Unnecessary Medications. (Residents 6 and 60)<br><br>Findings include: | F 0757 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 6 had no adverse effects from insulin administration.<br>Resident 60 orders updated to reflect monitoring of areas of | 05/28/2021 |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | 1. The record for Resident 6 was reviewed on 5/3/21 at 11:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes and weakness.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 2/3/21, indicated the resident was cognitively intact for daily decision making and received insulin injections.<br><br>The Care Plan, dated 8/3/20 and reviewed 2/2021, indicated the resident had an alteration in his blood glucose (blood sugar) level due to having diabetes mellitus. Interventions included, but were not limited to, administer medications as ordered.<br><br>The May 2021 Physician's Order Summary (POS), indicated the resident was to receive Humalog Mix 50/50 insulin, 20 units subcutaneously twice a day for diabetes. The insulin was to be held if the resident's blood sugar was less than 130.<br><br>The April 2021 Medication Administration Record (MAR) was reviewed. The resident received his insulin even though his blood sugar was less than 130 as follows:<br><br>7:00 a.m.: 4/5, 4/10, 4/14, 4/15, 4/24, and 4/29/21<br><br>4:00 p.m.: 4/5, 4/15, 4/19, 4/24, 4/25, and 4/30/21<br><br>Interview with the Interim Director of Nursing on 5/6/21 at 2:00 p.m., indicated the resident's insulin should have been held as ordered. 2. The record for Resident 60 was reviewed on 5/4/21 at 11:11 a.m. Diagnoses included, but were not limited to,cellulitis, acute respiratory failure, diabetes, atrial fibrillation, major depression, and obstructive sleep apnea. | | bruising and routine monitoring for s/s of bleeding.<br>2. How others residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Audit of all residents that routinely receive anticoagulant therapy completed to insure that all had orders to monitor for bleeding. Orders added for those that did not have order in place.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Licensed nurses provided with education related to reading insulin orders and follow the parameters for when to hold the insulin and to document appropriately. Education also provided in regard to monitoring for s/s of bleeding for residents receiving anticoagulant therapy.<br>4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or Designee will audit MARS for insulin parameters followed for 10 residents daily three times per week for 4 weeks, then two times per week x 4 weeks, then weekly x 4 months. Director of Nursing or Designee will audit 5 residents | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | The Annual Minimum Data Set (MDS) assessment, dated 3/16/21, indicated the resident was alert and oriented and required supervision with transfers. Medications received during the 7 day look back period included, but were not limited to, anticoagulants.<br><br>A revised Care Plan, dated 3/30/21, indicated the resident was at risk for complications related to anticoagulant medication use. The interventions included, but were not limited to, observe for signs and symptoms of bleeding such as tarry stools, blood in urine, bruising, and petechiae.<br><br>The April and May 2021 Treatment Administration Record indicated no documentation related to monitoring for signs and symptoms of bleeding.<br><br>Interview with the Interim Director of Nursing on 5/5/21 at 2:10 p.m., indicated residents who were prescribed anticoagulant medications should be monitored every shift for bleeding.<br><br>3.1-48(a)(3) | | that are receiving anticoagulant therapy to insure monitoring completed for s/s of bleeding three times per week x 4 weeks, then two times per week x 4 weeks, then weekly x 4 months. Discrepancies to be addressed upon noting. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |
| F 0812<br>SS=D<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food<br>Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. | | | |

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|---|---|---|---|
| | 155187 | A. BUILDING 00<br>B. WING | 05/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation and interview, the facility failed to ensure desserts were covered while serving for 1 of 1 meals observed on 1 of 4 halls. (The B hall)<br><br>Finding includes:<br><br>On 4/29/21 at 12:10 p.m., the first tray cart was delivered to the B hall. The cart was covered with plastic when it arrived on the unit. Two CNA's proceeded to uncover the cart and started serving the room trays. Observation at that time, indicated the desserts were not covered. There were trays on each shelf, of which some were below the waist level.<br><br>The residents that resided on the first hall and some of the residents from the middle hall were served from the cart.<br><br>Interview with the Interim Executive Director on 4/29/21 at 12:35 p.m., indicated the desserts had to be covered.<br><br>Interview with the Dietary Food Manager on 5/6/21 at 9:00 a.m., indicated the desserts should have been covered. | F 0812 | 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>No residents were affected by the deficient practice<br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>Whole house audit completed with no other residents identified.<br>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Education provided to Dietary employees on proper transportation of food.<br>4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:<br>Dietary Manager/Designee will audit tray carts prior to leaving the kitchen 3 times weekly for 4 | 05/28/2021 |

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| | 3.1-21(i)(3) | | weeks, then 2 times weekly for 4 weeks, then weekly for 4 months. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |
| F 0880<br>SS=E<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must | | | |

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| | include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | | | |

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| GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE | 3175 LANCER ST<br>PORTAGE, IN 46368 |

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| | The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly with resident interaction and not cleansing a tube feeding protective cap for random observations for infection control on 2 of 4 halls and for 1 of 1 gastrostomy tube medication administrations. (The B and ACU halls and Resident 39)<br><br>Findings include:<br><br>1. On 4/29/21 at 10:42 a.m., QMA 1 was observed preparing medications. The QMA was wearing trauma safety glasses with visible gaps on the sides and forehead. The QMA proceeded to enter a resident's room and administer medications within 6 feet of the resident.<br><br>The QMA indicated she was not aware her safety glasses could not be worn.<br><br>On 4/29/21 at 10:45 a.m., QMA 2 was observed preparing medications. The QMA was wearing trauma safety glasses with visible gaps on the sides and forehead. The QMA proceeded to enter a resident's room and administer medications within 6 feet of the resident.<br><br>Interview with the QMA at that time, indicated she would remove the glasses and either get a face shield or goggles.<br><br>Interview with the Interim Executive Director on 4/29/21 at 11:15 a.m., indicated staff should be | F 0880 | 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident 39 is without any adverse effects. Staff without adverse effects from not wearing appropriate eyewear. Verbally counseled immediately on the importance of wearing appropriate eyewear.<br>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:<br>All residents with feeding tubes were assessed and none were affected. No other residents were identified as being affected by inappropriate eyewear.<br>3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:<br>Licensed nurses and QMAS were educated on the need to properly clean caps prior to reusing them. All staff were educated on the proper use of PPE and shown what goggles meet the criteria. Competencies completed for donning and doffing of proper PPE and hand hygiene.<br>4.How the corrective action will be monitored to ensure the | 05/26/2021 |

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| | wearing either a face shield or goggles when completing care within 6 feet of a resident. 2. On 4/29/21 at 11:48 a.m., the locked Alzheimer's Care Unit (ACU) was observed. CNA 1, CNA 2, the Speech Therapist, and Activity Aide 1, were observed wearing trauma safety glasses with visible gaps within 6 feet of the residents.<br><br>Interview with the Interim Executive Director on 4/29/21 at 11:15 a.m., indicated staff should be wearing either a face shield or goggles when completing care within 6 feet of a resident.<br><br>The current and updated 3/31/21 Long Term Care "Use of Face shields or protective eyewear/goggles," indicated during moderate to high community transmission eye protection should be worn by HCP (Health Care Personnel) who provide essential direct care within 6 feet for any resident regardless of COVID status in all levels of care in LTC (long term care) settings. Thanks to a robust supply, face shields are the recommended source of eye protection; if you have access to goggles/safety glasses in your area, those are permitted as well. They must fit close to the face and not have gaps at the side, top and bottom of the glasses/goggles. 3. During an observation of a medication administration by the way of a gastrostomy tube (g-tube), on 5/3/21 at 3:54 p.m., LPN 4 removed a cap from on top of the feeding tube pole hook and placed it on the feeding tube. After LPN 4 had completed her medication administration, she removed the cap from the feeding tube and placed the cap back on top of the feeding pole hook. LPN 4 did not cleanse the cap before or after placement on the feeding tube.<br><br>Interview with LPN 4, on 5/3/21 at 4:00 p.m., indicated she was unaware the cap needed to be | | deficient practice will not recur, what quality assurance program will be put into place:<br>Director of Nursing or designee will observe three residents with tube feedings for proper cleaning of tubing cap and tip three times per week x 4 weeks, then two times per week x 4 weeks, then weekly x 4 months. Director of Nursing or designee will observe five staff members for use of proper eyewear five times per week x 4 weeks, then five staff members per day three times per week x 4 weeks, then five staff members per week x 4 months. Discrepancies will be addressed at the time noted. Audits will be submitted to QAPI monthly for 6 months with percentage of compliance. Modifications of frequency may be adjusted based on results. | |

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| | cleansed.<br><br>3.1-18(b) | | | |