

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

PRINTED: 04/11/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155136		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 01/30/2017	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVE LA PORTE, IN 46350			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00220548</p> <p>Complaint IN00220548 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250.</p> <p>Survey date: January 30, 2017</p> <p>Facility number: 000061 Provider number: 155136 AIM number: 100288620</p> <p>Census bed type: SNF/NF: 120 Total: 120</p> <p>Census payor type: Medicare: 14 Medicaid: 86 Other: 20 Total: 120</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 2/3/17.</p>		F 0000	<p>This Plan of Correction shall serve as this facility's credible allegation of compliance. Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in the survey.</p> <p>Respectfully, Jerrell Harville, HFA, MSW, Executive Director.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0250 SS=D Bldg. 00	<p>483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure medically related social services were provided upon discharge for 1 of 3 residents reviewed for discharge arrangements in a sample of 3. (Resident B)</p> <p>Finding includes:</p> <p>The closed record for Resident B was reviewed on 1/30/17 at 2:00 p.m. The diagnoses included, but were not limited to, diabetes mellitus, chronic obstructive pulmonary disease, congestive heart failure, high blood pressure, and cardiomyopathy (an enlarged heart).</p> <p>An Admission MDS (Minimal Data Set)</p>		F 0250	<p>Step One: Resident B is discharged from the facility on 1/2/2017.</p> <p>Step Two: The medical record was reviewed for residents discharged in the past 30 days to ensure all necessary medically related social services items were provided. No deficiencies were noted.</p> <p>Step Three: Licensed Nurses and Social Service Personal were re-educated regarding the Admission, Readmission, Bed Hold, and Transfer/Discharge Policy. The DNS and/or designee will review the Discharge Summary/Transfer Form prior to the resident discharge for 3</p>		02/23/2017	

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	<p>assessment was completed on 9/14/16. A BIMS (Brief Interview for Mental Status) assessment noted no cognitive deficits. No behaviors were exhibited and supervision was provided for ambulation in the room and corridor.</p> <p>The current POS (Physician Order Statement) was dated 12/2016. There were Physician orders for the resident to receive Albuterol 2.5 mg(milligrams)/3 ml (millimeters) inhaled orally via a nebulizer (breathing treatment device) four times a day. Physician orders for Metformin (medication to control Diabetes) 500 milligrams - two tablets twice a day were in place. Orders were also in place for Blood glucose testing three times a day per finger stick to be completed.</p> <p>Discharge orders were written on 12/30/16 to discharge home with medications and follow up with a Primary Care Physician in two weeks. A Discharge Nurses' Note was completed on 1/2/2017 (no time listed). Medication instructions were provided. The "Disposition of Meds" was not completed. The facility did not checked any of the four areas related to medications. The four areas to mark were "destroyed per policy", "returned to pharmacy for credit", "held per Doctor</p>		<p>discharges per week to ensure that appropriate medically related social service items are provided. The DNS will report findings to the QAPI committee monthly.</p> <p>Step Four: The results of the Discharge/Transfer Audit will be reviewed in the Clinical Start-Up Meeting weekly. The results will also be reviewed monthly by the QAPI Committee for six months. If after six months of review without any trends or patterns noted (3 deficient practices will be considered a trend or pattern), the results will be reviewed quarterly.</p>				

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	<p>order", or "released per Doctor ordered." None of the above areas were marked or addressed. There was no documentation related to blood glucose testing instructions or needed supplies provided.</p> <p>A Medication Disposition Record was completed on 1/2/17. Nursing staff completed the form and noted several medications were taken with the resident upon discharge. Albuterol (medication to control respiratory difficulty) nebulizer solution was not listed.</p> <p>An Interdisciplinary Discharge Summary was completed on 1/2/17 at the time of discharge from the facility. No equipment was needed for the post discharge plan of care. No Home Health services were needed. No equipment was need upon discharge.</p> <p>A Social Service Note was completed on 12/30/16 at 3:47 p.m. The resident was scheduled to be discharged on 1/2/17. No equipment or Home Health Services were needed upon discharge.</p> <p>The facility Social Worker was interviewed on 1/30/17 at 3:15 p.m. The facility supplied the discharged resident with a three day supply of medications that were newly initiated during the hospitalization. The resident was</p>						

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	<p>homeless upon admission to the facility and a center nearby had made housing arrangement for him upon discharge.</p> <p>The facility Administrator and Director of Nursing were interviewed on 1/30/17 at 4:45 p.m. The resident was living in his car prior to admission to the facility. Albuterol was not listed as one of the medications taken home. None of the discharge forms provided any record of a Nebulizer treatment machine and/or the Albuterol medication needed for treatments. No arrangements were made for delivery of or arrangements made for the nebulizer machine and/or medications upon discharge from the facility. Physician orders were in place for blood glucose levels to be checked three times a day at the time of discharge. No record or documentation of instructions or supplies need for blood glucose testing was noted.</p> <p>The current policy titled "Admission, Readmission, Bed Hold, and Transfer/Discharge" was provided and reviewed on 1/30/17 at 3:00 p.m. The policy was dated 11/23/16. The facility was to provide and document sufficient preparation and orientation to residents to "ensure a safe and orderly transfer or discharge" from the facility.</p>						

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	This Federal tag relates to Complaint IN00220548. 3.1-34(a)(5)						