STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	08/10/2017

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00237173 and IN00234971. Complaint IN00237173 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F322. Complaint IN00234971 - Unsubstantiated due to lack of evidence. Survey dates: August 9 and 10, 2017 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 150 Total: 150 Census Payor Type: Medicare: 8 Medicaid: 128 Other: 14 Total: 150 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections 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 The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Jason Eastlund, BSW, HFA	

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

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	Quality review completed on 8/16/17.			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care 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, including but not limited to the following: (k) Pain Management. 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. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional			

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	standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review, observation, and interview, the facility failed to assess and monitor a PICC line (Peripherally Inserted Central Catheter, a tube that is placed into a vein that connects to the heart to administer medication) for 1 of 2 residents reviewed for PICC lines. (Resident H) Finding includes: Resident H's record was reviewed on 8/9/17 at 3:15 p.m. Diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus and multiple myeloma. The current Physician Order Summary indicated: - measure the IV (Intravenous)-PICC line catheter (tubing) length with each dressing change on the evening shift every Friday to monitor - flush with 10 ml (milliliters) of NS (Normal Saline) every shift to maintain patency. The re-admission assessment, completed on 6/30/17, indicated the resident had a PICC line placed to the upper left arm. There was no documentation of the	F 0309	Res Identified Resident H had an x-ray to ensure that the line was intact on 8.10.17 Others All residents with pic lines were reviewed by the nursing department to ensure appropriate monitoring was in place for measuring lines, per policy. Education Licensed nursing staff was educated by the staff development coordinator on the policy for monitoring and measuring pic lines. Monitor All residents with pic lines will be reviewed by the nursing managers to ensure appropriate orders and documentation are occurring, per policy. Reviews will be conducted 3 X per week for 4 weeks, 3 X per month for 3 months and then quarterly until substantial compliance is achieved. QAPI All negative findings will be addressed and reviewed in monthly QAPI meeting.	09/08/2017

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	visible catheter length measurement upon admission after insertion. The June, July, and August MAR (Medication Administration Record) indicated the task to measure the length of the catheter was completed on Fridays, on evening shift, however, no measurements were recorded. Interview with Resident H on 8/9/17 at 4:00 p.m., indicated he did not know if the Nurse changed the dressing to his arm each week, and the Nurses measured the tubing once, "a long time ago." Interview with LPN 4 on 8/9/17 at 4:05 p.m., indicated she could not remember if she measured the PICC line when she changed the dressing or not, but there was a tape measure available in the dressing changing kit. There was not a place to document the measurement on the MAR. Interview with the B Wing Unit Manager on 8/9/17 at 4:06 p.m., indicated the resident's chart lacked information on how long the catheter tubing should be. Hospital records showed the length to be 42 cm from the resident's heart to his left upper arm when placed on 6/22/17, but nothing was recorded for the length of the external, visible tubing.			

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Interview with the Director of Nursing Services (DNS) on 8/10/17 at 8:46 a.m., indicated the Nurses should have been measuring the external catheter's length and the circumference of the resident's arm with each dressing change. The PICC line procedure orientation should have been completed during new employee orientation. LPN 4 was not a new nurse to the facility.

Interview with the Staff Development Coordinator on 8/10/17 at 8:55 a.m., indicated LPN 4 should have received orientation on PICC lines upon hire. LPN 4 was rehired on 4/28/16.

The policy titled, "Overview of IV Therapy, Overview: Types of Vascular Access Devices," was provided by the Director of Nursing Services on 8/10/17 at 8:50 a.m. This current policy indicated, "...d. Peripherally Inserted Central Catheter...(9) Upper arm circumference should be measured on admission and weekly to monitor for infiltration (leakage). (10) External catheter length should be monitored on admission, and weekly to monitor for outward migration of the catheter...."

This Federal tag relates to Complaint IN00237173.

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	3.1-37(a)			
F 0322 SS=D Bldg. 00	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (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- (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 (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 residents with a G-tube (gastrostomy tube inserted into the abdomen to deliver nutrition directly to the stomach) received the necessary care and treatment related to the incorrect length of time a resident's	F 0322	Res Identified Resident C had the order corrected in the point click care system to match the appropriate running time of 18 hours. This was completed by the unit manager. Nurse who	09/08/2017

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	tube feeding was administered and the placement of a Foley catheter (tube used to drain urine) into a resident's G-tube stoma (artificial opening made into a hollow organ) for 2 of 3 residents reviewed for tube feeding. (Residents C and B) Findings include: 1. On 8/9/17 at 9:30 a.m., Resident C was observed resting in bed. The residents G-tube was hooked up to the resident from the feeding pump but the pump was not turned on. Record review for Resident C was completed on 8/9/17 at 10:30 a.m. Diagnoses included, but were not limited to GERD (gastroesophageal reflux disease), heart disease, diabetes mellitus, and anxiety. The Admission MDS (Minimum Data Set) assessment, completed on 5/29/17, indicated the resident was cognitively impaired. The resident required the use of a feeding tube. A RD (Registered Dietician) note, completed on 7/26/17 at 2:58 p.m., indicated the resident had a recent weight loss of 6 lbs (pounds) in 3 weeks. The weight loss was not planned but may be		inputed the order was educated on the policy and procedure by the DNS. Others All other resident's with G- tubes were reviewed to ensure the order in point click care matched the appropriate running times. This was completed prior to date of compliance. Education All Licensed Nurses were educated on policy and procedure for G-Tube care by the SDC . Monitor All resident's who have a G -tube will be reviewed by the nursing managers to ensure times are running per physician order. Reviews will be conducted 3 X per week for 4 weeks, 3 X per month for 3 months and then quarterly until substantial compliance is achieved. QAPI All negative findings will be addressed and reviewed in the monthly QAPI meeting. Res Identified	

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	secondary to her diuretic use. The RD recommended to increase the tube feeding to Glucerna 1.2 at 75 ml (milliliters) an hour continuous for 18 hours. A Physician Order, dated 7/27/17, indicated Glucerna 1.2, give 75 ml/hr two times a day for nutrition. 75 ml/hr x 18. The July and August 2017 MARs (Medication Administration Records) indicated the resident received Glucerna 1.2, 75 ml/hr x 18 at 8:00 a.m., and 4:00 p.m. every day since July 28, 2017. The MAR lacked any indication of what time the feeding was supposed to start and what time it was to end daily. The time the resident was supposed to be on the tube feeding did not add up to 18 hours every day as currently scheduled. Interview with the C Wing Unit Manager (UM) on 8/9/17 at 11:15 a.m., indicated the resident was supposed to be on the tube feeding for 18 hours a day continuous. The feeding would start at 4:00 p.m., and be turned off at 8:00 a.m. Discussed with the UM that 4:00 p.m. to 8:00 a.m., would only add up to 16 hours and not the 18 hours for which the order was written. She was unaware the time was entered incorrectly and the order would be changed to start at 2:00 p.m.		Resident B was out to the hospital during survey and facility could not immediately address her issue. Licensed Nurse who placed Foley catheter in stoma was educated on policy and procedure for G-Tube care by the DNS, prior to date of compliance. Others All G- tubes sights were assessed to ensure appropriate placement and function. This was completed prior to date of compliance. Education All Licensed Nurses were educated on policy and procedure for G-Tube care by the SDC/ designee, prior to date of compliance. Monitor All residents who have a G- tube will be reviewed by the nursing managers to ensure optimal function. Reviews will be conducted 3 X per week for 4 weeks, 3 X per month for 3 months and then quarterly until substantial compliance is achieved. QAPI All negative findings will be addressed and reviewed in monthly QAPI meeting.	

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	and be stopped at 8:00 a.m., to ensure 18 hours of feeding was administered every day. Interview with the DNS (Director of Nursing Services) on 8/9/17 at 12:09 p.m., indicated there was an error with the timing for the resident's tube feeding. The resident had only been receiving the tube feeding for 16 hours a day instead of the 18 hours a day which was recommended by the RD. A policy titled, "Feeding Tube Review", and received as current from the DON on 8/9/17, indicated, "...Physician's Order for the use of the feeding tube should include: Length of time on enteral feeding per 24 hours...." 2. Record review for Resident B was completed on 8/9/17 at 9:45 a.m. Diagnoses included, but were not limited to, hypertension, dysphagia, and type 2 diabetes mellitus. A Progress Note, dated 7/20/17 at 6:00 a.m., indicated, a CNA reported to LPN 1 that Resident B's G-tube had come out and was lying on the resident's abdomen. LPN 1 notified the resident's Physician and the resident was sent to the hospital to replace the G-tube. A telephone interview with LPN 1 on			

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	8/10/17 at 10:21 a.m. indicated, on 7/20/17, she had been notified by the CNA that Resident B's G-tube had come out. She had inserted a Foley catheter (tube used to drain urine) into the G-tube stoma (site where G-tube enters the abdomen) and clamped it in order to keep the G-tube stoma open. She then notified the resident's Physician and sent the resident to the hospital. Interview with the Director of Nursing Services (DNS) on 8/9/17 at 4:30 p.m., indicated she had just spoken to LPN 1 on the telephone and LPN 1 indicated had inserted a Foley catheter into the G-tube stoma after Resident B's G-tube had come out to keep it open, and then sent the resident to the hospital. LPN 1 had not documented this information in the Progress Notes. The DNS educated LPN 1 regarding the facility policy on G-tube replacement and LPN 1 should not have inserted the Foley catheter into the G-tube stoma. A facility policy, titled "G-Tube Replacement Guideline," and received as current from the Staff Development Coordinator indicated, "...A Foley catheter should not be used for enteral feeding tube...Licensed staff will not re-insert the G-tube...G-tubes are not placed by licensed nurses in the center...."			

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	This Federal tag relates to Complaint IN00237173. 3.1-44(a)(2)			