STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155062	A. BUILDING 00 B. WING	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-LAPORTE	1700 I STREET LA PORTE, IN 46350

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00226192. Complaint IN00226192- Substantiated. Federal/State deficiencies related to the allegation are cited at F328. Survey date: April 20, 2017 Facility number: 000023 Provider number:155062 AIM number: 100289400 Census bed type: SNF/NF: 57 Total: 57 Census payor type: Medicare: 11 Medicaid: 38 Other: 8 Total: 57 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4.24.17.	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 determined that other safegaurds 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 0328 SS=D Bldg. 00	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must			

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	be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (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. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.			
	Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen not administered as order by the Physician for 1 of 3 residents reviewed for respiratory care in a sample of 3. (Resident C) Finding includes: On 4/20/17 at 10:17 a.m., Resident C was seated in a wheelchair in the Therapy Department. A portable oxygen tank was attached to the back of the wheelchair	F 0328	F328 1. Oxygen flow rate for Resident C was corrected immediately per LPN 1 when the deficient practice was identified. Resident C was assessed per the Director of Nursing (DNS) and LPN 1 for adverse affects related to oxygen flow being set incorrectly with no shortness of breath or respiratory distress noted or voiced and residents oxygen saturation level was noted at 94%.	05/05/2017

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	with the tubing attached to the resident through a nasal cannula. The oxygen tank was set at 2 L (liters). On 4/20/17 at 10:47 a.m., Resident C was seated in a wheelchair in the Therapy Department. He was assisted by Physical Therapy Assistant 1 (PTA 1) and Certified Occupational Therapist Assistant 1 (COTA 1) with an exercise hand bike. The resident's portable oxygen tank was attached to the back of the wheelchair with the tubing attached to the resident through a nasal cannula. The tank was set at 0. Record review for Resident C was completed on 4/20/17 at 9:13 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), heart failure, hypertension, and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, completed on 3/12/17, indicated the resident was cognitively intact and was on oxygen therapy. A Care Plan indicated the resident had an alteration in respiratory status due to COPD, and sleep apnea. An intervention included to administer oxygen as needed as ordered by the Physician.		2. Director of Nursing completed a facility wide audit of all residents with oxygen therapy to identify any other residents who may have been affected by the deficient practice with no other deficiencies identified. Certified Occupational Therapist Assistant 1 (COTA 1) and Physical Therapy Assistant 1 (PTA 1) were re-inserviced on the "Oxygen Administration Policy" (see attachment) per the Director of Clinical Education (DCE) on 4/20/2017. 3. A. Nursing staff and Therapy staff were re-inserviced on the "Oxygen Administration Policy" (see attachment) per the Director of Clinical Education (DCE). B. DNS applied a sticker with a number only (ie. 1, 2, 3, ect.) on all oxygen concentrators and portable oxygen tanks to alert staff to the correct flow rate required for each resident receiving oxygen therapy per the physicians' order. Stickers will be updated with new orders per the Licensed nurse receiving the order and reviewed per the DNS or designee with "Daily Start Up" (see attachment). C. Random rounds will be completed 2x/week on all 3 shifts per a nurse manager and weekly per the DNS or designee of all	

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	The April 2017 Physician Order Summary (POS) indicated an order, dated 4/10/17, for oxygen at 3 L continuous. Interview with LPN 1 on 4/20/17 at 10:17 a.m., indicated the resident's portable oxygen tank was set at 2 L. PTA 1 and COTA 1 were interviewed on 4/20/17 at 10:47 a.m. COTA 1 had assisted the resident with walking from the Therapy Department to his room. Once he was back into his room she had turned off his portable oxygen tank to place him back on the concentrator, but then realized he had not completed the hand bike exercise yet. She had brought him back to the therapy room to complete the exercise, but forgot to turn his portable tank back on. Interview with the Director of Nursing (DON) on 4/20/17 at 11:00 a.m., indicated the resident was supposed to be on 3 L of oxygen. Therapy had placed the resident on the portable oxygen tank when they took him to therapy and put it on the incorrect setting of 2 L instead of 3 L. A policy titled, "Oxygen Administration (via Nasal Cannula)" and given as current by the DON on 4/20/17, indicated,		residents receiving oxygen therapy utilizing the "Oxygen Tracking Log" (see attached) to ensure they are receiving the correct flow rate of oxygen per their physician's order. D. Any deficient practice identified during rounds will be corrected immediately per the DNS or designee with follow up re-education to occur per the DCE with any staff member responsible for the deficient practice. 4. DNS will present the findings of the rounds to the Quality Assessment Process Improvement (QAPI) Committee monthly. The QAPI committee will review for any trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations. If after 90 days of review, no trends or patterns are identified then results will be reviewed quarterly. 5. 5/5/2017	

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	"..."Connect the nasal cannula to the oxygen source and turn flow meter to the appropriate flow as ordered by the physician...." This Federal Tag relates to Complaint IN00226192. 3.1-48(c)(1)			