

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
--	--

(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 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00170748 and Complaint IN00171848.</p> <p>Complaint IN00170748 Substantiated - Federal/State deficiencies are cited at F332.</p> <p>Complaint IN00171848 Substantiated - Federal/State deficiencies are cited at F332.</p> <p>Survey dates: April 23 and 24, 2015</p> <p>Facility number: 000152 Provider number: 155248 AIM number: 100267510</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 8 Medicaid: 55 Other: 13 Total: 76</p>	F 000		
-----------------------	---	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
--	--

(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 332 SS=D Bldg. 00	<p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure</p>	F 332	1 - unable to correct within physician order time limit 2 - all residents receiving insulin will be	05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
--	--

(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
	<p>a medication error rate was less than 5% for 1 of 2 residents observed during a medication administration observation in a sample of 7, in that, 2 errors were made out of 27 opportunities for error, resulting in an error rate of 7.4 % (Resident F, Resident G)</p> <p>Findings include:</p> <p>1. On 4/23/15 at 9:15 A.M., during a medication administration observation, RN # 1 was observed giving Resident G her medications. Resident G propelled herself down the hallway before getting her insulin injection. LPN # 1, who was in orientation, reminded RN # 1 about the resident's insulin. RN # 1 indicated, "Oh, yeah. I need to give that to her."</p> <p>On 4/23/15 at 9:35 A.M., RN # 1 was observed to go to Resident G's room. Resident G was not in her room. A staff member indicated, "She's probably in therapy." RN # 1 indicated she would administer the insulin when the resident was out of therapy.</p> <p>On 4/23/15 at 10:30 A.M., RN # 1 indicated the resident was "still in therapy." She indicated she had not administered the resident her insulin yet.</p> <p>On 4/23/15 at 11:10 A.M., the Director</p>		<p>audited to insure administration per physician's orders 3 - DNS or designee with audit insulin administration times against physician's orders for correct insulin administration X2/week for 3 months, then X1/week for 3 months and then X1 month for 3 months. 4 - Results will be reported to QAPI</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
--	--

(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
	<p>of Nursing (DON) was informed of the lack of the insulin administration.</p> <p>On 4/23/15 at 11:15 A.M., the clinical record of Resident G was reviewed. Diagnoses included, but were not limited to, diabetes type 2 uncontrolled.</p> <p>A Physician's order, dated 4/22/15, indicated, "Levemir [insulin]...Inject 5 units...two times a day..." The resident had an additional physician's order, dated 4/16/15, for "Novolog [insulin]...sliding scale...before meals...."</p> <p>On 4/23/15 at 11:45 A.M., RN # 1 was observed administering the insulin to Resident G. The resident's Medication Administration Record (MAR) was reviewed at that time, and indicated the medication should have been given at "9:00 A.M." RN # 1 indicated at that time that the resident had her accucheck at 6:00 A.M., and her sliding scale coverage was administered at that time.</p> <p>The "Prescribing Information" for Levemir included: "Patients adjusting the amount or timing of dosing with Levemir should only do so under medical supervision...."</p> <p>2. On 4/23/15 at 9:55 A.M., RN # 1 was observed administering medications to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
--	--

(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
	<p>Resident F. She looked for the ordered Lantus insulin, and indicated there was none in the facility. She then indicated she called the pharmacy and told them to deliver it "stat." RN # 1 indicated the pharmacy had recently switched their insulin from vials to insulin pens.</p> <p>On 4/23/15 at 10:30 A.M., RN # 1 indicated the resident's insulin had not yet been delivered.</p> <p>On 4/23/15 at 11:10 A.M., the DON was notified of the lack of insulin administration.</p> <p>The clinical record of Resident F was reviewed on 4/23/15 at 11:15 A.M. Diagnoses included, but were not limited to, diabetes type 2 uncontrolled.</p> <p>A Physician's order, dated 4/16/15, indicated, "Lantus [insulin]...Inject 44 units subcutaneously two times a day." The resident had an additional physician's order, dated 4/16/15, for "Humalog insulin sliding scale...before meals and at bedtime...."</p> <p>The resident's Medication Administration Record indicated the insulin was to be administered at 9:00 A.M.</p> <p>On 4/23/15 at 12:10 P.M., the DON</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 30 E CHANDLER AVE EVANSVILLE, IN 47713
--	--

(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
	<p>indicated Resident F was going to receive her insulin at that time, and that the resident's physician had been notified.</p> <p>The "Prescribing Information" for Lantus insulin included: "Administer...at the same time every day...."</p> <p>This Federal tag relates to Complaint IN00170748 and Complaint IN00171848.</p> <p>3.1-25(b)(9)</p>			