STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING 00 B. WING	01/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on December 1, 2011. Survey Date: January 17, 2012 Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210 Survey Team: Beth Walsh, R.N., TC Barbara Hughes, R.N. Census Bed Type SNF/NF: 86 Total: 86 Census Payor Type Medicare: 20 Medicaid: 64 Other: 2 Total: 86 Sample: 11 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

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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	Quality review completed 1/18/12 Cathy Emswiller RN			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician's orders for 1 of 2 residents, reviewed for correct insulin administration for sliding scale insulin orders, in a total sample of 11 (Resident #86). Findings include: The clinical record for Resident #86 was reviewed on 1/17/12 at 4:00 p.m. The diagnoses for Resident #86 included, but were not limited to: diabetes mellitus. A recapitulation of the January of 2012 Physician Orders, indicated Novolog (insulin treatment of blood sugar/glucose levels) was to be given per sliding scale of subsequent blood sugars (BS) from an Accucheck measurement. The sliding scale was BS 131-180=2 units of Novolog, BS of 181-240= 4 units of Novolog, BS of 241-300=6 units of Novolog, BS of 301-350=8 units of Novolog, and 351-400=10 units of Novolog. Glucose greater than 400, give 12 units of Novolog and call MD (medical doctor). A review of the January of 2012 Diabetic	F0282	**Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the 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.** F282 Corrective action: Insulin orders of resident #86 were reviewed and verified with MD and were re-written to ensure orders are easily read. Licensed nurses re-educated on correct order entry and importance of clarity of order on Medicine Acceptance Record. Other residents affected: Other residents with sliding insulin scale have the potential to be affected by alleged deficient practice. After review no other discrepancies were noted with residents with sliding scale insulin orders. Systemic changes: Directed in-servicing will be completed per the Formal Notice of Implementation of Remedies regarding facility policies and procedures concerning medication administration to include physician's orders by	02/03/2012

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	Monitoring Flow Sheet indicated that the following dates had the incorrect units of Novolog given according to the January Physician Orders. 1/1/12 at 4:00 p.m.-BS=211, 2 units of Novolog were given and 4 units should have been given 1/2/12 at 4:00 p.m.-BS=234, 2 units of Novolog were given and 4 units should have been given 1/5/12 at 4:00 p.m.- BS=354, 8 units of Novolog were given and 10 units should have been given 1/6/12 at 5:00 a.m.-BS=254, 4 units of Novolog were given and 6 units should have been given 1/6/12 at 4:00 p.m.- BS=356, 8 units of Novolog were given and 10 units should have been given 1/7/12 at 5:00 a.m.-BS=253, 4 units of Novolog were given and 6 units should have been given 1/7/12 at 5:00 p.m.-BS=395, 8 units of Novolog were given and 10 units should have been given 1/8/12 at 11:00 a.m.-BS=300, 4 units of		State Clinical Director and Clinical Services Consultants for licensed nurses in the facility. After alleged compliance date any nurse who has not completed the directed in-servicing will be removed from the schedule until required in-servicing has been completed. Facility wide audit completed to ensure no other residents are affected. DNS or designee will verify new sliding scale orders daily for clarity and accuracy by comparing the original order to the Medicine Acceptance Record. Monitoring: DNS or designee will monitor the Medicine Acceptance Record from all shifts five times a week for four weeks; three times a week for four weeks; one time a week for four weeks; monthly times four months; then quarterly thereafter to ensure proper insulin coverage and documentation is obtained. DNS or designee will review audits for trends and patterns. Any concerns will be taken to QAA for review. Date of Completion: February 3, 2012	

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	Novolog were given and 6 units should have been given 1/14/12 at 4:00 p.m.-BS=191, 2 units of Novolog were given and 4 units should have been given 1/15/12 at 4:00 p.m.-BS=378, 8 units of Novolog were given and 10 units should have been given 1/16/12 at 5:00 p.m.-BS=273, 4 units of Novolog were given and 6 units should have been given In an interview on 1/17/12 at 4:20 p.m., with the DoN (Director of Nursing), she indicated that she had no explanation why the wrong units were given for the above blood sugars, except that maybe the documentation on the MAR (medication administration record) was difficult to read. 3.1-35(g)(2)			

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F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure medication administration was free from significant medication error for 1 of 2 residents reviewed for insulin administration in a total sample of 11 (Resident #86). Findings include: The clinical record for Resident #86 was reviewed on 1/17/12 at 4:00 p.m. The diagnoses for Resident #86 included, but were not limited to: diabetes mellitus. A recapitulation of the January of 2012 Physician Orders, indicated Novolog (insulin treatment of blood sugar/glucose levels) was to be given per sliding scale of subsequent blood sugars (BS) from an Accucheck measurement. The sliding scale was BS 131-180=2 units of Novolog, BS of 181-240= 4 units of Novolog, BS of 241-300=6 units of Novolog, BS of 301-350=8 units of Novolog, and 351-400=10 units of Novolog. Glucose greater than 400, give 12 units of Novolog and call MD (medical doctor). A review of the January of 2012 Diabetic	F0333	F333Corrective action: Insulin orders of resident #86 were reviewed and verified with MD and were re-written to ensure orders are easily read. Licensed nurses re-educated on correct order entry and importance of clarity of order on Medicine Acceptance Record. Other residents affected: Other residents with sliding insulin scale have the potential to be affected by alleged deficient practice. After review no other discrepancies were noted with residents with sliding scale insulin orders. Systemic changes: Directed in-servicing will be completed per the Formal Notice of Implementation of Remedies regarding facility policies and procedures concerning medication administration to include physician's orders by State Clinical Director and Clinical Services Consultants for licensed nurses in the facility. After alleged compliance date any nurse who has not completed the directed in-servicing will be removed from the schedule until required in-servicing has been completed. Facility wide audit completed to ensure no other residents are affected. DNS or designee will verify new sliding scale orders daily for clarity and accuracy by comparing the original order to the Medicine	02/03/2012

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