

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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 Recertification and State Licensure survey.</p> <p>Survey dates: May 18, 19, 20, 21, 22, 2015</p> <p>Facility number: 000411 Provider number: 155384 AIM number: 100275100</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 6 Medicaid: 60 Other: 13 Total: 79</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>Preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility set forth. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and Title 19 programs. We would like to request a desk review. Thank you Julie Pennington</p>	
F 282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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>facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physician's orders were followed for the administration of medications, in that, insulin was not administered according to the physician's order for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #60)</p> <p>Findings include:</p> <p>Resident #60 was observed on 5/18/15 at 12:00 P.M. sitting in a wheel chair at the dining room table, in no apparent distress.</p> <p>The clinical record of Resident #60 was reviewed on 5/20/15 at 8:25 A.M. The record indicated the diagnoses of Resident #60 included, but were not limited to, Diabetes Mellitus.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 2/15/15 indicated Resident #60 experienced severe cognitive impairment, and received insulin daily.</p> <p>The most recent Physician's Order Recap dated 5/1/15 included, but was not</p>	F 282	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The glucometer order was corrected to reflect sliding scales insulin doses to give according to glucometer readings for Resident #60. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. We checked the glucometer orders of all residents with sliding scale insulin and corrected to reflect sliding scales insulin doses to give according to glucometer readings. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Education will be provided to the nurses to ensure glucometer orders of all residents with sliding scale insulin reflect sliding scales insulin doses to give according to glucometer readings. Audits will be conducted by the DNS or designee five times weekly for two months, four days a week for one month, three days a week for a month, two days a week for a month, and one day a week for a month. How will the corrective</p>	06/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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>limited to, orders for:</p> <p>"...glucometer check q [every] am [morning] cover with prn [as needed] sliding scale one time a day..."</p> <p>"...Humulin R (a faster-acting insulin)...inject as per sliding scale 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401-450=12 units if above 450 give 15 units and call md [sic] [medical doctor], subcutaneously every 24 hours..."</p> <p>A Care Plan dated 12/24/13 for "...Potential for alteration in blood glucose levels...r/t [related to] diabetes..." included, but was not limited to, interventions of "...administer ...medications as ordered..."</p> <p>The May 2015 MAR (Medication Administration Record) lacked any documentation Resident #60 received Humulin R insulin per sliding scale on the following dates:</p> <p>5/1/15 at 6:00 A.M. for glucometer result of 154 mg(milligram)/dl (deciliter). (2 units of Humulin R should have been administered)</p>		<p>actions be monitored? The audit results will be monitored through the monthly QAPI process for six months or until corrective action is no longer needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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
	5/3/15 at 6:00 A.M. for glucometer result of 154 mg/dl (2 units of Humulin R should have been administered)			
	5/4/15 at 6:00 A.M. for glucometer result of 194 mg/dl (2 units of Humulin R should have been administered)			
	5/7/15 at 6:00 A.M. for glucometer result of 225 mg/dl (4 units of Humulin R should have been administered)			
	5/11/15 at 6:00 A.M. for glucometer result of 182 mg/dl (2 units of Humulin R should have been administered)			
	5/12/15 at 6:00 A.M. for glucometer result of 199 mg/dl. (2 units of Humulin R should have been administered)			
	5/13/15 at 6:00 A.M. for glucometer result of 158 mg/dl (2 units of Humulin R should have been administered)			
	5/15/15 at 6:00 A.M. for glucometer result of 156 mg/dl (2 units of Humulin R should have been administered)			
	5/16/15 at 6:00 A.M. for glucometer result of 213 mg/dl (4 units of Humulin R should have been administered)			
	5/17/15 at 6:00 A.M. for glucometer			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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 371 SS=F Bldg. 00	<p>result of 159 mg/dl (2 units of Humulin R should have been administered)</p> <p>5/18/15 at 6:00 A.M. for glucometer result of 208 mg/dl (4 units of Humulin R should have been administered)</p> <p>During an interview on 5/20/15 at 11:30 A.M., the ADON (Assistant Director of Nursing) indicated Resident #60 had not received sliding scale insulin as directed because the order had not been entered into the computer system correctly and had not prompted nursing staff to administer the medication.</p> <p>A Policy and Procedure for Medication Administration provided by the ADON on 5/20/15 at 11:30 A.M. indicated, "...B...2.) Medications are administered in accordance with written orders of the prescriber..."</p> <p>3.1-35(g)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure open food packages were dated and/or leftover food items had been discarded promptly, and a floor area was without soiling. This had the potential to affect 79 of 79 residents who resided in the facility.</p> <p>Findings included:</p> <p>The following were observed on 5/18/15 at 8:39 A.M.:</p> <ol style="list-style-type: none"> <li>1. A two quart pitcher of cranberry drink and 2-two quart pitchers of an orange drink were in the reach-in fridge undated. The Food Service Manager (FSM) indicated the drinks needed to be dated.</li> <li>2. The walk-in freezer contained an opened bag of dinner rolls which lacked documentation of an opening date. The FSM indicated the dinner rolls would be discarded.</li> <li>3. The walk-in refrigerator contained a bag of left over food consisting of 3 cooked strips of bacon and 3 cooked sausage patties with a date of 5/14/15. The FSM removed for discarding.</li> </ol>	F 371	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The top surface of the toaster was cleaned. The microwave was cleaned. The spices will be placed in ziploc bags with a date indicating when opened. The fan was removed. The floor will be stripped and repaired. All leftover food was discarded. Drink pitchers will be properly labeled. Left over food will be placed in a sealed container and labeled with the name of the food and date prepared. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. All items will be cleaned, repaired and corrected. All food and drink items will be properly labeled. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Education will be provided to the dietary staff on proper sanitation techniques, discarding of outdated food/ labeling of food and proper labeling of drink pitchers. The Dietary Services Manager/Designee will conduct audits five days a week for six</p>	06/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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>4. The walk-in refrigerator contained a opened bag of salad mix and an opened bag of slaw that lacked documentation of opening dates. The FSM removed for discarding.</p> <p>The following were observed on 5/20/15 at 9:46 A.M.:</p> <p>5. The top surface of the toaster was covered with dust and finger prints were left in the dust when a hand swipe was completed across the top of the toaster. The FSM agreed the toaster surface was soiled.</p> <p>6. The microwave had red food spillage across the top inside surface. The FSM indicated the microwave would be cleaned.</p> <p>7. Two containers of spices, onion flakes and chili powder had lids that were open. All of the spice containers on a shelving unit had lids that were soiled with food particles. The FSM discarded the 2 spice containers at that time.</p> <p>8. A fan sitting on the floor was blowing air across a shelving unit which contained clean, drying kitchen items. The kitchen fan's wire blade guard was entirely coated with dust.</p>		<p>months. How will the corrective actions be monitored? The audit results will be monitored through the monthly QAPI process for six months or until corrective action is no longer needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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>9. The section of painted kitchen floor which contained the heating cooling unit and the walk-in freezer had missing paint and a large amount of black soilage through out and along the floor edges and around the heating cooling unit.</p> <p>Facility documentation entitled, "Cleaning Kitchen Areas " (dated 2/12/15) was provided on 5/19/15 at 3:04 P.M. The documentation included, but was not limited to, "...check walls, ceilings, floors and vents for chipped and/or peeling paint, and keep in good repair... ..Heavily soiled surfaces need to be cleaned more often... ..Follow the steps below to mop kitchen floors daily: ...7 Begin at the rear of the room and use a figure- 8 motion to mop. Mop one small area at a time. Note: Be sure to mop under and around equipment, along walls and in corners..."</p> <p>The FSM was interviewed on 5/21/15 at 8:10 A.M. She indicated the discard date for leftover foods was 3 days. She also indicated food items stored in refrigerators and freezers needed to be labeled and dated after opening.</p> <p>Facility documentation entitled, "COLD FOOD STORAGE" (undated) indicated, Refrigerated storage... foods must be maintained at or below 41 (degree</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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>symbol) unless otherwise specified by law. All opened container should have date opened marked to assure correct rotation. Use the following guideline for dating foods stored in refrigerator.</p> <p>Prepared Potentially Hazardous Foods: Foods mixed with other Ingredients, Foods cooked...Use- By Date: 3rd day after placing in refrigerator..."</p> <p>On 5/21/15 at 9:49 A.M., the FSM provided facility documentation entitled Daily Dining Dept [Department]. Closing List" (revision date 2/2015). The documentation included, but was not limited to, "...check dates on stored leftover items- throw out according to guidelines..."</p> <p>3.1-21(i)(3)</p>			