

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/11/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|-------|---|-------|--|--|
| F0000 | <p>This visit was for the Investigation of Complaints IN00120016 and IN00120275.</p> <p>Complaint IN00120016-Substantiated. Federal/state deficiencies related to the allegations are cited at F253, F314, and F322.</p> <p>Complaint IN00120275-Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F314, and F514.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN0118989 completed on November 7, 2012.</p> <p>Survey dates: December 9, 10 & 11, 2012</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Survey team: Janet Adams, RN, TC Janelyn Kulik, RN</p> <p>Census bed type: SNF/NF: 140</p> | F0000 | | |
|-------|---|-------|--|--|

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: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>Total: 140</p> <p>Census payor type: Medicare: 19 Medicaid: 101 Other: 20 Total: 140</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> | | | | |

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | | |
| (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 | | | |
| F0253 SS=D | <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure housekeeping services were provide to maintain a clean environment related to dried tube formula on tube feeding poles and pumps for 2 of 3 resident rooms observed with tube feedings on 1 of 3 resident units. (The 300 Unit)</p> <p>Findings include:</p> <p>1. On 12/9/12 at 11:35 a.m., a large accumulation of dried tube feeding formula was observed on the base of the tube feeding pole in room 306-2. The area of dried tube feeding formula covered approximately half of the pole base. The dried tube feeding remained on the tube feeding pole on 12/9/12 at 12:25 p.m., 12:50 p.m., 2:10 p.m. and 4:05 p.m.</p> <p>On 12/10/12 at 12:25 p.m., 2:25 p.m., and 3:30 p.m., dried tube feeding formula was observed on the tube feeding pole as was noted on 12/9/12.</p> <p>When interviewed on 12/10/12 at 3:30 p.m., the Assistant Director of Nursing indicated the tube feeding pole had an</p> | F0253 | <p>F253</p> <p><i>It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · The tube feeding pole/pump in Room 306-2 was deep cleaned on 12-10-12 · The tube feeding pole/pump in Room 308-1 was deep cleaned on 12-10-12 <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · A facility wide sweep of all tube feeding poles/pumps was conducted and all poles were deep cleaned on 12-10-12 <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <ul style="list-style-type: none"> · In-service completed for nursing staff regarding their responsibility to maintain and clean the tube feeding poles | 12/17/2012 | | | |

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>accumulation of dried tube formula and was in need of cleaning.</p> <p>2. On 12/9/12 at 11:40 a.m., accumulation of dried tube feeding formula was observed on the base of the tube feeding pole and on the back of the tube feeding pump in room 308-1. The dried tube feeding formula remained on the tube feeding pole and pump on 12/9/12 at 12:29 p.m.</p> <p>On 12/10/12 at 12:20 p.m., 2:00 p.m., and 3:30 p.m., the dried tube feeding was still observed on the tube feeding pole and pump.</p> <p>When interviewed on 12/10/12 at 3:30 p.m., the Assistant Director of Nursing indicated the tube feeding pole and pump was in need of cleaning.</p> <p>This federal tag relates to Complaint IN00120016.</p> <p>3.1-19(f)</p> | | <p>and pumps when administering medications , flushes and feedings.</p> <ul style="list-style-type: none"> · All departments staff received in-servicing conducted per Executive Director regarding the awareness and importance of focusing on cleanliness of the resident's environment. · ACE (guardian angels) audit/round sheets have been updated to include verification of cleanliness of feeding tube poles/pumps · A member of nursing management and/or unit charge nurse will assess/audit the feeding tube poles/pumps daily on each shift. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · The daily feeding tube pole/pump audits will be reviewed each morning by the DNS/ADNS to ensure that the daily audits are completed. This daily auditing will be for 6 weeks. If audits indicated that poles/pumps are being maintained in a clean status then audits will be decreased to 3 times weekly x 4 weeks and then 2 times weekly x 4 weeks and then will be completed weekly as an | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>ongoing process.</p> <ul style="list-style-type: none"> o Results of audits will be reviewed monthly in the QA&A committee meeting. · Documented daily random time of day audits of tube feeding poles/pumps will be completed by the DNS and/or ADNS and/or DCE.(This will be a “check the checker” program) These audits will be completed for 6 weeks. If audits indicated that poles are being maintained in a clean status then audits will be decreased to 3 times weekly x 4 weeks and then 2 times weekly x 4 weeks and then will be completed weekly as an ongoing process. o Results of audits will be reviewed monthly in the QA&A committee meeting. · A summary of the ACE audits/rounds related to the cleanliness of tube feeding poles/pumps will be reviewed monthly at the QA&A meeting. These results will also be a part of the evaluation for possible decreasing the number of days a week the audits are completed by the Nursing management staff. · The Executive Director and the Director of Nursing Services will oversee this system. <p><i>By what date the systemic</i></p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/11/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 |
|---|---|

| (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><i>changes will be completed?</i></p> <p>December 17, 2012</p> | |

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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 | |
| F0309 SS=D | <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to assess a resident with an elevated blood glucose level for signs and symptoms of a hyperglycemic reactions for 1 of 4 residents reviewed for blood glucose monitoring in the sample of 8. (Resident #E)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #E was reviewed on 12/10/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, dementia, pressure ulcer, and high blood pressure.</p> <p>Review of the 5/2102 Medication Administration Record indicated there was a Physician's order for Accucheck blood glucose monitoring to be completed three times a day at 6:00 a.m., 11:00 a.m., and 5:00 p.m. The Medication Administration Record indicated the resident's blood glucose level was 443 on 5/27/12 at 5:00 p.m.</p> | F0309 | <p>F309 <i>It is the practice of this facility to ensure that facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> No further action can be taken for this resident due to resident has been discharged from the facility since 5/30/12. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> No action can be taken at this time for any resident who may have previously been affected by the same alleged deficient practice. Diabetic residents will | 12/17/2012 | |

| | | | | | |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>Review of the 5/2102 Nursing Progress Notes indicated there was no documentation of the resident being assessed for any signs or symptoms of complications related to the elevated glucose level on 5/27/12 at 5:00 p.m. An entry made on 5/29/12 at 6:07 p.m. indicated the resident's blood glucose level was 400 at 4:00 p.m. and the resident was given 20 units of Novolin Regular insulin as ordered by the Physician. There was no documentation of the resident being assessed for any signs or symptoms of complication related to the elevated glucose level.</p> <p>When interviewed on 12/11/12 at 9:00 a.m., the facility Administrator indicated there was no assessment of the resident at the time of the elevated blood glucose levels.</p> <p>This federal tag relates to Complaint IN00120275.</p> <p>3.1-37(a)</p> | | <p>have their MAR reviewed daily to ensure that blood sugar/ accu-checks were completed and documented as ordered. Any resident found to have blood sugar/accu-check above or below call perimeters will be assessed for any signs or symptoms of complications related to the blood sugar/accu-check level. Documentation of this assessment will be completed in an SBAR (change of condition documentation) format per PCC. (Computerized medical record) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> In-servicing will be completed with nurses regarding assessments of residents with blood sugars/accu-checks out of perimeters and on documentation follow up as an SBAR. A member of nursing management will review MARs daily of all diabetic resident's who receive blood sugar/accu-checks with call perimeters to ensure that any resident who had a blood sugar/ accu-check which fell outside of the call perimeters had an assessment completed and documented, along with | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>proper coverage and MD and family notification.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · A member of nursing management will review the MAR of identified Diabetic residents daily to ensure that all blood sugar/accu-checks have had proper follow through including: documentation of results, proper administration and documentation of coverage, documentation of needed assessments, documentation of MD and family notification. · Documented audits of blood sugars/ accu-checks will be completed daily x 6 weeks and then 3 times weekly x 4 weeks and then 2 times weekly x 4 weeks and then weekly x 3 months. All results of audits will be reviewed at the monthly QA&A committee meeting. · The DNS/ADNS/DCE will review the daily audit sheets (check the checker) each day x 6 weeks and then twice weekly x 3 months and then weekly x 3 months. This will ensure that audits are completed and that proper follow up documentation is completed. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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 | |
| | | | <ul style="list-style-type: none"> · Implementation of electronic MARs will be initiated in facility January 8, 2012. eMARS will be reviewed daily for blood sugar/accu-check documentation through the daily clinical AMALGA review. This will be an ongoing process. · The Executive Director and the Director of Nursing Services will oversee this process. <p><i>By what date the systemic changes will be completed?</i></p> <ul style="list-style-type: none"> · December 17, 2012 | | |

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | | |
| (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 | | | |
| F0314 SS=D | <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Registered Dietitian's recommendations for protein supplements were addressed in a timely manner for 1 of 3 residents reviewed for pressure ulcers in the sample of 8. (Resident #D)</p> <p>Findings include:</p> <p>During orientation tour on 12/9/12 at 9:50 a.m. Resident #D was observed in bed. The resident was receiving tube feeding through a PEG (Pecutaneous Endoscopic Gastrostomy). The resident also had wound vac (a device which provides suction to aid in healing of wounds) in place to a pressure ulcer on the coccyx.</p> <p>The record for Resident #D was reviewed on 12/9/12 at 3:00 p.m. The resident's diagnoses included, but were not limited</p> | F0314 | <p>F 314</p> <p><i>It is the practice of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <p>No further action can be taken for Resident #D. Prostat Profile 30cc was initiated on 11-20-12.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> | 12/17/2012 | | | |

| | | | | | | | |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | | |
| (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>to, congestive heart failure, cardiovascular disease, epilepsy(seizure disorder), diabetes mellitus, and atrial fibrillation(an irregular heart rhythm). The resident was admitted to the facility in 10/2012. The resident was sent to the hospital on 11/5/12 and was re admitted to the facility on 11/9/12.</p> <p>Review of the 11/2012 Physician orders indicated an order was written on 11/20/12 for the resident to receive Prostat Profile 30 mls (millimeters) once a day.</p> <p>The 11/2012 Wound Evaluation Flow Sheets were reviewed. A Wound Evaluation Flow Sheet initiated on 11/9/12 indicated the resident was admitted with a pressure ulcer to the coccyx measuring 2.0 cm(centimeters) x 0.5 cm. x 0.2cm. The wound bed was 50% slough(necrotic or avascular tissue in the process of separating from viable tissue) and 50% red tissue to the wound bed. The wound measured 3.0 cm. x 2.4 cm. with 50% slough and 50% red. The wound measured 7.0 cm. x 8.0 cm. on 11/22/12.</p> <p>A re-admission note was completed by the Registered Dietitian on 11/12/12 at 10:49 a.m. This note indicated the resident returned from the hospital on</p> | | <ul style="list-style-type: none"> · A 30 day look back (audit) will be completed on all Dietary recommendations to ensure completion. · Any dietary recommendation found to not have been completed will have resident reviewed by Dietician again along with any further recommendations. MD will also be notified of any recommendations that he may not have been previously notified of. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <ul style="list-style-type: none"> · Unit Managers and Weekend Supervisor have received in-servicing on timely completion of all Dietary Recommendations. Weekend Supervisor will complete recommendations which may have been made on Friday. · Unit Managers will bring a copy of all completed Dietary Recommendations to the Clinical Review each morning. This form will be kept as a documented audit tool. · The Registered Dietician will bring recommendations from previous day to the Clinical Review Meeting each morning and assist in verifying completion of recommendations. | | | | |

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>11/9/12 and was noted to have skin breakdown. The Registered Dietitian recommended Prostat Profile (a liquid protein supplement 30 cc (cubic centimeters) once a day be started to provide additional protein related to the resident's skin breakdown.</p> <p>A Change of Condition Assessment note was made by the Registered Dietitian on 11/16/12 at 11:45 a.m. The note indicated the resident was noted to have skin breakdown to the coccyx. Recommendations made again included for the resident to receive Prostat Profile 30 cc every day for additional protein related to skin breakdown.</p> <p>When interviewed on 12/9/12 at 3:25 p.m., the Assistant Director of Nursing indicated the facility protocol related to dietary recommendations was for the Dietitian to leave any recommendations with each Unit Manager and also provide the Director of Nursing with a copy. The Assistant Director of Nursing indicated the protocol was for the recommendations to be acted upon with 72 hours The Assistant Director of Nursing indicated the recommendation for the Prostat for Resident #D was not completed as per the protocol.</p> <p>This federal tag relates to Complaint</p> | | <ul style="list-style-type: none"> · Any recommendation which is related to skin/wound will be reviewed during the daily Clinical Review meeting to verify that recommendation was completed. · <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i> · Review of completed Dietary Recommendations will be a part of the Clinical Review meeting daily as an ongoing process. · A summary of Dietary Recommendations and timeliness of completion will be brought to the monthly QA&A meeting by the Registered Dietician as an ongoing process. · The Executive Director and the Director of Nursing will oversee this process. · <i>By what date the systemic changes will be completed?</i> · December 17, 2012 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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 | |
| | IN00120016 and Complaint IN00120275. 3.1-40(a)(2) | | | | |

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | | |
| (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 | | | |
| F0322 SS=D | <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure water flushes were administered through PEG (pecutaneous endoscopic gastrostomy) feeding tubes as per the facility policy for 1 of 2 residents observed for the administration of medications and water flushes through PEG tubes. (Resident #B)</p> <p>Findings include:</p> <p>On 12/9/12 at 1:10 p.m., LPN #1 was observed preparing medications for Resident #B. The LPN poured 4 mls (millimeters) of Dilantin (a medication to control seizures) into a plastic medication cup. The LPN then poured 10 mls of Metoclopramide liquid into another medication cup.</p> <p>LPN #1 then entered the resident's room with the above medications. The LPN</p> | F0322 | <p>F 322</p> <p><i>It is the practice of this facility to ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · LPN #1 was immediately in-serviced on proper procedure for administration of medications and water flushes for resident #B. <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <ul style="list-style-type: none"> · LPN # 1 also completed competency training/testing prior to administering any medications/flushes or | 12/17/2012 | | | |

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>unclamped the resident's PEG (pecutaneous endoscopic gastrostomy) tube and checked placement of the PEG tube by injecting a small amount of air into the PEG tube using a syringe. The LPN auscultated the resident's abdomen with a stethoscope while injecting the air bolus. The LPN then pulled back the plunger of the syringe to check for any residual tube feeding. LPN #1 then drew up water into the syringe and injected the water into the resident's PEG tube by pushing the water through the syringe using the plunger part of the syringe. The syringe was filled with approximately 30 cc (cubic centimeters) of water. The LPN then administered the medications through the PEG tube by allowing the medications to flow through the PEG tube by gravity.</p> <p>The clinical record for Resident #B was reviewed on 12/9/12 at 11:50 a.m. The resident's diagnoses included, but were not limited to, gastrostomy(feeding tube inserted into the stomach), Vitamin D deficiency, joint contractures, cerebral palsy, and pressure ulcer. Review of the 12/12 Physician Order Sheet indicated there was a Physician's order for the resident to receive Jevity tube feeding at 45 cc (cubic centimeters) per hour for 18 hours a day. There was also an order to use approximately 60 cc of water to dilute</p> | | <p>feedings for any other residents who also utilize gastric tubes for medications or nutrition.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <ul style="list-style-type: none"> · Nurses were re-educated and competencies were completed regarding gastric tube medication/fluid administration. · Nurses will have multiple documented observation checks weekly x 6 weeks to ensure proper follow through with facility policy and procedure. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · Nurses will have multiple documented observation checks weekly x 6 weeks to ensure proper follow through with facility policy and procedure. · Monthly documented observations of medication/fluid administration will be completed with nurses x 6 months. · Competency checks will be completed quarterly as an ongoing process. · Review of these | | |

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | | |
| (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>and flush medications.</p> <p>The facility policy titled "Medication Administration Enteral Tubes" was received from the facility Administrator on 12/9/12 at 1:50 p.m. The Administrator identified the policy as current. The policy was dated 10/07. The policy indicated enteral tubes are to flushed before and after administering medications and after all medications have been administered with at least 30 ml of water. The policy indicated staff were to verify the tube placement by unclamping the tube, inserting a small amount of air into the stomach with a syringe and listen to the stomach upon injection. Staff then were to aspirate (pull back) stomach contents to check for tube feeding residual(excess tube feeding formula left in the stomach). The next step in the policy indicated staff were to remove the plunger from the syringe and flush the tube with at least 30 ml of water.</p> <p>When interviewed on 12/9/12 at 1:35 p.m., LPN #1 indicated she filled half of the syringe with water and administered the water through the syringe by using the plunger in inject the water. The LPN indicated this was the procedure she followed to administer water and medication through PEG tubes.</p> | | <p>documented observations will be brought to the monthly QA&A Meeting.</p> <ul style="list-style-type: none"> The Executive Director and the Director of Nursing Services will oversee this process. <p><i>By what date the systemic changes will be completed?</i></p> <ul style="list-style-type: none"> December 17, 2012 | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/11/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 |
|---|---|

| (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>When interviewed on 12/9/12 at 2:30 p.m., the Director of Nursing indicated the standard required is to allow the medications and water to flow into the PEG tube by gravity.</p> <p>This federal tag relates to Complaint IN00120016.</p> <p>3.1-44(a)(2)</p> | | | |

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | | |
| (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 | | | |
| F0514 SS=E | <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to medications not signed out and blood glucose levels not signed out on the Medication Administration Records for 4 of 8 residents reviewed for clinical records in the sample of 8. (Residents #D, #E, #F, and #G)</p> <p>Finding include:</p> <p>1. Then closed record for Resident #E was reviewed on 12/9/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, dementia, pressure ulcer, and high blood pressure.</p> <p>Review of the 5/2012 Medication</p> | F0514 | <p>F 514 <i>It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</i></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <ul style="list-style-type: none"> · No further action can be taken for Resident #E. Resident was discharged from facility on 5-30-12. · No further action can be taken for past holes in records for Resident #D. Resident was assessed and MD was notified of lack of documentation. No new orders received. | 12/17/2012 | | | |

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>Administration Record indicated there was a Physician order for the resident to receive an injection of 40 unit of Lantus insulin every night at bed time. The Lantus injection was not signed out as given on 5/18/12, 5/20/12, and 5/21/12. The 5/2012 Medication Administration Record also indicated there was also a Physician order for the resident to receive Blood Glucose testing three times a day at 6:00 a.m., 11:00 a.m., and 5:00 p.m. The results of the 6:00 a.m. blood glucose level was not documented on 5/23/12.</p> <p>Review of the 3/2012 Physician Order Statement indicated there was an order for the resident to have blood glucose testing completed once a day. Review of the 3/2012 Medication Administration Records indicated no record of the 3/2012 blood glucose monitoring results could not be located in the resident's closed record.</p> <p>When interviewed on 12/11/12 at 8:10 a.m., the facility Administrator indicated the medications and blood glucose levels were to be documented on the Medication Administration Records. The facility Administrator also indicated the facility was unable to locate the page of the 3/2012 with the results of the resident's blood glucose monitoring.</p> | | <ul style="list-style-type: none"> · No further action can be taken for past holes in records for Resident #F. Resident was assessed and MD was notified of lack of documentation. No new orders received. · No further action can be taken for past holes in records for Resident #G. Resident was assessed and MD was notified of lack of documentation. No new orders received. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i> · Diabetic residents will have their MAR reviewed daily to ensure that blood sugar/ accu-checks were completed and documented as ordered and that insulin was administered and documented as ordered. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i> · In-servicing will be completed with nurses regarding documentation of administration of medication and documentation of blood sugar/accu-check results and coverage. · A member of nursing management will review MARs daily of all diabetic resident's who receive blood | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
|---|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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. The record for Resident #D was reviewed on 12/9/12 at 3:00 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, cardiovascular disease, epilepsy(seizure disorder), diabetes mellitus, and atrial fibrillation(an irregular heart rhythm). The resident was admitted to the facility in 10/2012. The resident was sent to the hospital on 11/5/12 and was re admitted to the facility on 11/9/12.</p> <p>Review of the 11/2102 Medication Administration Record indicated there was a Physician order for the resident to have blood glucose monitoring four times a day with a Novolin Regular insulin given based on a sliding scale at 6:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. The resident's 6:00 a.m. blood glucose level was not documented on 11/12/12, 11/13/12, 11/24/12, and 11/27/12.</p> <p>When interviewed on 12/11/12 at 8:10 a.m., the facility Administrator indicated the medications and blood glucose levels were to be documented on the Medication Administration Records.</p> | | <p>sugar/accu-checks to ensure that results were documents and followed up on as per the physicians orders.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <ul style="list-style-type: none"> · A member of nursing management will review the MAR of identified Diabetic residents daily to ensure that all blood sugar/accu-checks have had proper follow through including: documentation of results, proper administration and documentation of coverage, documentation of needed assessments, documentation of MD and family notification. · Documented audits of blood sugars/ accu-checks will be completed daily x 6 weeks and then 3 times weekly x 4 weeks and then 2 times weekly x 4 weeks and then weekly x 3 months. All results of audits will be reviewed at the monthly QA&A committee meeting. · The DNS/ADNS/DCE will review the daily audit sheets (check the checker) each day x 6 weeks and then twice weekly x 3 months and then weekly x 3 months. This will ensure that audits are completed and that proper follow up documentation is completed. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>3. The record for Resident #F was reviewed on 12/9/12 at 12:35 p.m. The resident's diagnoses included, but were not limited to, dementia, hypertension, depression and diabetes mellitus.</p> <p>Review of the Mediation Administration Record for October, 2012 indicated there was no blood surgar documented on 10/25/12 at 6:00 a.m.</p> <p>Review of the Medication Administration Record for November, 2012 indicated there were no blood sugars documented on 11/19/12 at 6:00 a.m., 11/20/12 at 1600 (4:00 p.m.), and on 11/28/12 at 1600 (4:00 p.m.).</p> <p>Review of the Medication Administration</p> | | <ul style="list-style-type: none"> · Implementation of electronic MARs will be initiated in facility January 8, 2012. eMARS will be reviewed daily for blood sugar/accu-check documentation through the daily clinical AMALGA review. This will be an ongoing process. · The Executive Director and the Director of Nursing Services will oversee this process. <p><i>By what date the systemic changes will be completed?</i></p> <ul style="list-style-type: none"> · December 17, 2012 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 | |
|---|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | | |
| (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>Record for December, 2012 indicated there was no blood sugar documented on 12/2/12 at 1600 (4:00 p.m.).</p> <p>Interview with the Administrator on 12/11/12 at 8:05 a.m., indicated she had contacted staff and they had the blood sugars written in a note book at home for Resident #F. The blood surgars were obtained from the Nurse over the phone.</p> <p>4. The record for Resident #G was reviewed on 12/9/12 at 1:10 p.m. The resident's diagnoses included, but was not limited to, edema, depression, hypertension, and diabetes mellitus.</p> <p>Review of the Medication Administration Record for September, 2012 indicated there were no blood sugars documented on 9/13/12 at 1600 (4:00 p.m.), 9/20/12 at 1600 (4:00 p.m.), and 9/27/12 at 1600 (4:00 p.m.).</p> <p>Review of the October, 2012 Medication Administration Record, indicated there was no blood sugar documented on 10/18/12 at 1600 (4:00 p.m.).</p> <p>Review of the November, 2012 Medicaiton Administration Record, indicated there were no blood sugars documented on 11/15/12 at 1600 (4:00 p.m.) and 11/19/12 at 1600 (4:00 p.m.)</p> | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/11/2012 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410 | | |
| (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>Review of the December, 2012 Medication Administration Record, indicated there was no blood sugar documented on 12/6/12 at 6:00 a.m.</p> <p>Interview with the Adminsitrator on 12/11/12 at 8:10 a.m., indicated she had obtained the blood sugar results from the Nurse at home who had them written in a notebook. She also indicated the Nurse would have to bring in her notebook and copies would be made of the blood sugar results. She futher indicated the residents records did not have the blood sugars documened in the medical record.</p> <p>This Federal tag relates to complaint IN00120275.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p> | | | | |