

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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
F000000	<p>This visit was for the Investigation of Complaint IN00155136.</p> <p>Complaint IN00155136- Substantiated. No deficiencies related to the allegation were cited.</p> <p>Unrelated deficiencies were cited at F309 and F441.</p> <p>Survey dates: September 8 & 9, 2014</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Survey team: Regina Sanders, RN-TC</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census Payor type: Medicare: 07 Medicaid: 68 Other: 05 Total: 80</p> <p>Sample: 4 Supplemental sample: 2</p>	F000000	F000 - Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this 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.	

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: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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
F000309 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 11, 2014, by Janelyn Kulik, RN.</p> <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. Based on record review and interview, the facility failed to ensure necessary care and services were attained, related to not following the facility's policy for CPR (Cardio Pulmonary Resuscitation) and</p>	F000309	<p>F309 -</p> <p>1) Resident "B" expired prior to survey.</p> <p>2) All residents have the potential</p>	09/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383		
(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>assessment of a resident who was found without vital signs (temperature, pulse, respirations, and blood pressure) for 1 of 1 closed record review in a total sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's closed record was reviewed on 09/09/14 at 10:53 a.m. The resident's diagnoses included, but were not limited to cerebral ventricular shunt, Alzheimer's disease, chronic atrial fibrillation, chronic diastolic congestive heart failure, and chronic kidney disease.</p> <p>A resuscitation order form, signed by the resident's Power of Attorney, dated 03/28/14, indicated, "...in the event of cardiac and/or respiratory arrest, initiate CPR..."</p> <p>The Advance Directives Summary Sheet, dated 03/28/14, indicated the resident was a "full code" (initiate CPR).</p> <p>The Physician's Order Summary, dated 07/14, indicated to administer CPR. The order had been updated on 05/16/14.</p> <p>A Nurses' Note, dated 07/18/14 at 2:30 a.m., indicated, "Writer called to room by staff member regarding resident. Upon entering writer found resident to have no</p>		<p>to be affected by the alleged deficient practice. All residents will have their code status assessed. MD and Family will be notified of any concerns.</p> <p>3) In-service for nurses on completing assessment and documentation of an unresponsive resident, CPR and Code Status policy completed. Code Status Review Audit tool will be used to verify that appropriate documentation has been completed.</p> <p>4) Code Status Review Audit tool will be completed by the DNS/designee 5 times per week times 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly, times 6 months in facility QAPI meeting.</p> <p>5) September 26, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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>vitals. Status verified by second nurse. MD (Physician) notified and did not administer CPR per MD order. POA notified and writer instructed to release resident to (Funeral Home Name)."</p> <p>The Nurses' Note lacked documentation to indicated a full assessment of the condition of the resident, other than the vital signs had been completed by the Nurse.</p> <p>A Physician's Telephone Order, dated 07/18/14 at 3:12 a.m., indicated, "ok to not administer CPR per MD."</p> <p>During an interview on 09/09/14 at 1:31 p.m., with the Director of Nursing (DoN) and the Staff Educational Coordinator (SEC), the DoN indicated the facility policy was, when a resident was found without vital signs was to call for help, check the resident's CPR status and if the resident was a, "full code", CPR was to be initiated immediately. She indicated the Nurse should have initiated CPR on the resident. She indicated the facility policy stated to start CPR. The DoN indicated an investigation of the incident had not been completed because she had not been aware the resident was a full CPR status.</p> <p>During an interview on 09/09/14 at 3:01</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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>p.m., with the DoN and the SEC, the SEC indicated he had reviewed another policy (Advance Directive Review) and the policy stated the facility could take a CPR order from the Physician over the phone. The SEC indicated he had just spoken to the resident's Physician and the Physician indicated he had given the order not to initiate CPR. He said the Physician recalled the Nurse had informed him the Resident's body temperature had already dropped. The SEC indicated the facility policy for CPR had not been followed.</p> <p>During an interview on 09/09/14 at 3:21 p.m., the Administrator indicated he had just notified the resident's Physician and asked the Physician if he remembered the incident. He indicated the Physician said he remembered and gave an order to the Nurse not to initiate CPR.</p> <p>During a telephone interview on 09/09/14 at 3:25 p.m., LPN #2 (Nurse working the 07/18/14) indicated when the CNA's were completing their every two hour rounds, around 2:30 a.m., they called her to the room. She indicated when she entered the room the resident was non-responsive. She indicated the resident had already, "passed". She indicated the resident was not breathing and had no other vital signs. She</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383		
(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 she had gone to the Nurses' Station and found out the resident was a full CPR so she called the resident's Physician and he gave an order not to start CPR. She indicated the resident's body temperature had already dropped. She indicated she was going to initiate CPR, but the resident would not have been able to be revived. She indicated there was a RN working as a CNA that night and the RN was already in the room when she entered the resident's room. (Attempts were made to contact the other RN working 07/18/14 and unable to reach the RN)</p> <p>A facility policy, titled, "Emergency Action Plan-Code", not dated and received from the DoN as current on 09/08/14 at 1:40 p.m., indicated, "...What to Do in case of a CODE:...Identify patient's current code status. Initiate CPR (if indicated). EMS (Emergency Medical System) is called...Announce, 'code blue'...Until EMS arrives, all employees will follow the direction of the employee in charge..."</p> <p>A facility policy, dated 01/29/14, titled, "Advance Directive Review", received from the SEC as current, indicated, "...To ensure the Medical Record reflects the Resident's and/or the surrogate decision-maker's health care decision as</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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
F000441 SS=D	<p>to Advance Directives...Each Medical Record should have an Advanced Directive Acknowledgement form, signed by Resident/Responsible Party on admission or as soon after, as possible...NOTE: A telephone order for 'No CPR' or DNR (Do Not Resuscitate)' may be accepted, if Resident acknowledgement and the physician documentation of discussion with the Resident and/or Surrogate Decision Maker are included in the Medical Record, at the time the telephone order is obtained. With a telephone order, it is suggested to have two licensed nurses sign the telephone order..."</p> <p>3.1-37(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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>infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to follow standard cleaning precautions during the performance of routine testing of blood glucose levels, related to disinfecting a blood glucose monitor (checks blood sugars) after usage from one resident to another resident, this had the potential to affect 2 of 2 residents in a supplemental sample of 2, who required blood glucose monitoring who reside on the Alzheimer's Care Unit. (Residents #F and #G)</p>	F000441	<p>F441 -</p> <p>1) Resident "F" and Resident "G" were assessed without negative findings and the glucometer was cleaned per policy.</p> <p>2) All residents have the potential to be affected by the alleged deficient practice. In-service staff nurses on following Glucometer decontamination cleaning policy and procedure.</p> <p>3) In-service nursing staff on following the glucometer</p>	09/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383			
(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>Findings include:</p> <p>During an observation on 09/08/14 at 5:07 p.m., LPN #1 administered a blood glucose test to Resident #F. After the resident's blood glucose was obtained, LPN #1 then placed the glucometer in her pocket of her uniform top and exited the resident's room. LPN #1 then exited the room and placed the glucometer in the top drawer of the Medication Cart. LPN #1 did not disinfect the glucometer after the usage of the monitor for Resident #F.</p> <p>LPN #1 was then observed on 09/08/14 from 5:07 p.m. through 5:37 p.m. At 5:37 p.m., LPN #1 then removed the glucometer from the Medication Cart and indicated Resident #G required a blood glucose test. LPN #1 prepared the supplies of a lancet, alcohol prep pad, and glucometer. LPN #1 then started to walk from the cart towards Resident #'sG room with the glucometer in her hand.</p> <p>During an interview on 09/08/14 at 5:37 p.m., LPN #1 indicated she should have disinfected the glucometer after using it for Resident #F. She indicated the glucometer was to be cleaned after each use. She then obtained an alcohol prep pad and started to clean the glucometer. LPN #1 further indicated she was unsure</p>		<p>decontamination cleaning policy and procedure. DNS/designee will use the glucometer cleaning audit tool to observe and verify the cleaning is performed accurately.</p> <p>4) DNS/designee will use the glucometer cleaning audit tool to observe 5 times per week times 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly, times 6 months in facility QAPI meeting.</p> <p>5) September 26, 2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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>what the facility policy was for cleaning/disinfecting the glucometer. She indicated she had always used the alcohol prep pad.</p> <p>During an interview on 09/08/14 at 5:47 p.m., LPN #1 indicated there were disinfectant wipes in the he bottom drawer of the Medication Cart, which the other Nurses' may have used. LPN #1 again indicated she had always used the alcohol prep pads. LPN #1 further indicated she had asked the Staff Educational Coordinator and was informed she was to use a,"Gluco-Chlor" wipe.</p> <p>During an observation on 09/08/14 at 5:47 p.m., LPN #1 opened a package, which contained a wipe. LPN #1 then used the wipe to clean the glucometer. LPN #1 then placed the glucometer on top of the Medication Cart for one minute, then LPN #1 obtained a lancet and alcohol prep pad and carried the glucometer toward Resident #G's room. During an interview at this time, LPN #1 indicated after reading the package of the cleaning wipes, the glucometer was to remain wet for five minutes.</p> <p>The "Gluco-Chlor" wipe, (LPN #1 used to clean glucometer prior to the bleach wipes being delivered) package, reviewed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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>on 09/08/14 at 5:47 p.m., indicated, "...SPECIAL INSTRUCTIONS FOR CLEANING AND DECONTAMINATION AGAINST HIV-1 (associated with AIDS)...Blood and body fluids...CONTACT TIME: allow surface to remain wet for 5 minutes..."</p> <p>During an interview with the Staff Educational Coordinator (SEC) on 09/08/14 at 5:55 p.m., indicated the Nurses' were to use bleach wipes to clean the glucometer after each use. He indicated the glucometer was to remain wet for three minutes when using the bleach wipes. The SEC then placed a container of bleach wipes in the bottom of the Medication Cart. The SEC then indicated the disinfectant wipes, which were already in the Medication Cart, were bleach free and was not effective for blood borne pathogens.</p> <p>During an interview on 09/08/14 at 5:56 p.m., LPN #1 indicated there were two residents on the Alzheimer's Care Unit who had orders for glucose monitoring.</p> <p>A facility policy, dated 06/12, titled, "Blood Glucose Monitor Decontamination", received from LPN #1 as current, indicated, "...After performing the glucose testing, the nurse, wearing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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
	gloves, will use a Clorox wipe to clean all external parts of the monitor. III. A second wipe will be used to disinfect the blood glucose monitor. IV. The disinfected monitor will be placed on another clean surface..." 3.1-18(a) 3.1-18(j)			