

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  07/16/2014
--	---	--	---

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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaints IN00152114, IN00152215, and IN00152579.</p> <p>Complaint IN00152114- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00152215- Substantiated. Federal/State deficiencies related to the allegations are cited at F363 and F465.</p> <p>Complaint IN00152579- Substantiated. Federal/State deficiency related to the allegations is cited at F465.</p> <p>Survey dates: July 14, 15, &amp; 16, 2014</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Survey team: Janet Adams, RN-TC Lara Richards, RN (July 16, 2014)</p> <p>Census bed type: SNF/NF: 134 Total: 134</p>	F000000		
---------	---	---------	--	--

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  07/16/2014
--	---	--	---

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
F000363 SS=E	<p>Census payor type: Medicare: 10 Medicaid: 105 Other: 19 Total: 134</p> <p>Sample: 11</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 19, 2014, by Janelyn Kulik, RN.</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review, and interview, the facility failed to ensure menus were followed related to milk not served to 17 residents in the ACU Unit Dining Room for (1) of (2) Dining Rooms observed during meal services. (The ACU (B-Wing) Dining Room)</p> <p>Findings include:</p>	F000363	<p>F363</p> <p>All 17 residents had tray tickets evaluated and honored preferences immediately.</p> <p>All residents with preference of milk with meals have potential to be effected by this deficient practice.</p> <p>In-servicing was done with Dietary</p>	08/15/2014

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  07/16/2014
--	---	--	---

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>The Evening meal service was observed in the ACU Dining Room on 7/14/14 at 5:50 p.m. Bowls of meat, scalloped potatoes, and broccoli were placed on each table. Some residents were observed using utensils to place foods on their plates. Staff assisted residents if needed.</p> <p>No pitchers, glasses, or cartons of milk were noted in the Dietary delivery cart or the two rolling carts with coffee carafes and juice pitchers. Fourteen residents were noted to have 2% milk listed on their meal tray cards on the Dining Room tables they were seated at. No milk was served to these residents during the meal service.</p> <p>The Therapeutic Menu Spreadsheet for the 7/14/14 Dinner meal was reviewed. The Spreadsheet indicated 2% milk was to be served to residents on Regular, Mechanical Soft, Controlled Carbohydrate, No Added Salt, and No Salt Packet diets.</p> <p>When interviewed on 7/15/14 at 9:35 a.m., the Dietary Manager indicated if milk was listed on the resident's tray cards they were to be served milk with the Breakfast and Dinner meals daily.</p> <p>When interviewed on 7/15/14 at 1:35</p>		<p>staff regarding tray and menu accuracy with pre and post test. All residents with the preference of milk will receive cartons on their trays, in this way we eliminate the opportunity for missing the milk pass in the dining area.</p> <p>A Beverage Delivery Tracking Form has been implemented in order to monitor the Dietary staff in appropriate beverage delivery. Dietary will utilize this form daily for one month, if no trends then weekly for one month and then monthly for 6 months. Dietary Manager will QAPI the findings for two consecutive months and thereafter if needed.</p> <p>Facility will be in compliance by August 15, 2014</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  07/16/2014
--	---	--	---

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
F000465 SS=E	<p>p.m., the Kitchen Manager indicated she spoke with the kitchen staff who prepared the Dinner meal cart for the ACU unit on 7/14/14. The Kitchen Manager indicated the staff members indicated the milk was not sent out to the ACU unit as required.</p> <p>This Federal tag relates to Complaint IN00152215.</p> <p>3.1-20(i)(4)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide housekeeping and maintenance services to maintain a functional, sanitary, and comfortable environment related to dirty walls, blinds, wheelchairs, and cabinets and marred walls, peeling wallpaper, rusty commode chairs, and floors, and dirty wheelchairs on (3) of (3) Units. (The B, C, and D Units) (Residents #K, #M, and #N).</p>	F000465	<p>F465</p> <p>Immediately the dried spillage, chipped paint, peeled wallpaper, dirty blinds, crumbs, marred walls, plaster chipped, loose or missing cove trim, rust and paint chipped on commode chair, floor tiles, dust, furniture in disrepair and wheelchair cleaning were cleaned and repaired. The vent cover was permanently repaired with a new cover and paint.</p>	08/15/2014

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  07/16/2014
--	---	--	---

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>Findings include:</p> <p>1. During observation of the Evening Meal service in the B (ACU) unit Dining Room on 7/14/14 at 5:50 p.m. the following was observed:</p> <p>a. There was dried spillage on the lower parts of the back wall and the wall to the left of the doorway entrance.</p> <p>b. The paint was chipped on the wall above the counter with the sink and stove. There was spillage on the wall also.</p> <p>c. There was dried spillage on the drawers of the cabinets under the sink counter.</p> <p>d. The wall paper was peeling on the wall above the sink counter.</p> <p>e. There was dried spillage on the door and sides of the refrigerator.</p> <p>f. The white window blinds were dirty. The cover at the end of the register running along the bottom of the window was missing. There were crumbs on the ceramic ledge under the windows.</p> <p>2. The following was observed in the B</p>		<p>All residents have the potential to be effected by this deficient environmental practice.</p> <p>Line items have been added to Maintenance and Housekeeping forms to include; Housekeeping will be monitoring/rounding daily for environmental cleanliness of spillage, blinds, crumbs, and dust. Maintenance will be monitoring/rounding weekly for chipped paint, peeling wallpaper, marred walls, plaster chipped, cove trim missing or loose, floor tile repaired or replaced. New furniture was ordered to replace the furniture in disrepair In-servicing was done with CNA's regarding linens removed promptly from shower rooms after showers are given. In-servicing was done with staff regarding wheelchair cleaning and schedule. Wheelchair schedule was created and implemented with staff. Unit Managers will be doing visual checks in shower rooms daily for any linen issues and cleanliness of wheelchairs; any identified issues will be reported at start up meeting.</p> <p>Monthly during QAPI Maintenance and Housekeeping will be reporting on the findings of their monitoring /rounding in an ongoing basis. DNS will QAPI the wheelchair cleanliness for 3 months and if no</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  07/16/2014
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>(ACU) unit on 7/14/14 at 6:40 p.m.</p> <p>a. The leather upholstery on the black love seat was peeling in the seats and arm rests in the Living Room.</p> <p>b. The walls in the Living Room were marred and scraped.</p> <p>c. The paint and plaster on the corner near the Bathroom door was chipped down to the plaster in the Living Room.</p> <p>3. The following was observed in the B (ACU) unit on 7/14/14 at 6:50 p.m.</p> <p>a. The wall corners around the door frame were chipped in the "Garage" room. There was spillage and crumbs on the shelves in the Garage.</p> <p>b. There was an accumulation of crumbs in slots of the wall register unit.</p> <p>c. The paint on the walls next to the bathroom in the Garage was chipped down to the plaster of an area approximately 2 feet long.</p> <p>4. During the Environmental Tour on 7/16/14 at 10:45 a.m., the following was observed on the C-wing:</p> <p>a. The cove base was peeled off on the</p>		<p>identified issues it will drop to every quarter.</p> <p>Facility will be in compliance by August 15th, 2014</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  07/16/2014
--	---	--	---

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>corner of the wall in Room 228 by the bathroom door. Two residents resided in this room.</p> <p>b. The paint was chipped and rust noted on the bars under the seat and the sides of a commode chair over the toilet in the bathroom in Room 232. Two residents resided in this room.</p> <p>c. Six floor tiles were missing on the bottom of the wall by the grab bar in the Tub Room. There was a pile of wet bath blankets on the floor next to the toilet in the Tub Room. There were three brown spots on the privacy curtain around the toilet.</p> <p>d. The wall paper in the Rehab Dining Room was peeling and there was red spillage on the wall .</p> <p>5. During the Environmental Tour on 7/16/14 at 11:00 a.m., the following was observed on the D-wing:</p> <p>a. There was an accumulation of dust on the round fan hanging in the Nurses Station.</p> <p>b. A section of cove base was missing by the closet in Room 303. There was an accumulation of rust in the corners of the bathroom. One resident resided in this</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  07/16/2014
--	---	--	---

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>room.</p> <p>6. On 7/15/14 at 11:15 a.m., Residents #K, Resident #N, and Resident #M were observed sitting in wheelchairs in the Dining Room on the D-Wing. There was dust and dirt on the wheelchair spokes and the bars on the bottom of Resident #K's wheelchair. There was dried substance on the cushioned arm pads on the arm rest of Resident #K's wheelchair. The spokes on the wheels of Resident #M's wheelchair were dirty and dusty. The bars on the bottom and sides of Resident #N's wheelchair were dirty.</p> <p>7. On 7/16/14 at 9:42 a.m., Resident #N was observed sitting in a wheelchair in her room.. The wheelchair bars were dirty.</p> <p>When interviewed on 7/16/14 at 11:30 a.m., the Housekeeping Supervisor and the Maintenance Director indicated the above areas were in need of cleaning or repair.</p> <p>This Federal tag relates to Complaints IN00152215 and IN00152579.</p> <p>3.1-19(f)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

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 07/16/2014
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	