

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
---	--

(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 a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaints IN00155592, IN00155844, IN00153982 and IN00153717 completed on 9/22/14.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00157218.</p> <p>Complaint IN00155592- corrected.</p> <p>Complaint IN00155844- corrected.</p> <p>Complaint IN00153982- corrected.</p> <p>Complaint IN00153717- corrected</p> <p>Survey dates: November 5 and 6, 2014.</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Survey team: Yolanda Love, RN-TC Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: SNF/NF: 154 Total: 154</p>	F000000	<p>This Plan Of Correction constitutes the facility's written allegation of compliance for the deficit sited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. The facility, Golden Living Center - Fountainview Place, respectfully requests consideration of this Plan of Correction to be granted paper compliance.</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: 155187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/06/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368			
(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			
F000371 SS=D	<p>Census payor type: Medicare: 22 Medicaid: 122 Other: 10 Total: 154</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 10, 2014, by Janelyn Kulik, RN.</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 (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions related to transporting lunch trays with uncovered food from the Main Kitchen to Unit C. (Unit C)</p> <p>Findings include: On 11/06/2014 at 1:10 p.m., lunch trays</p>	F000371	F 371 Food Procure/Store/Prepare The corrective action(s) that were accomplished for the resident found to have been affected by the deficient practice: Unable to correct the alleged deficient practice for Unit-C. How other Residents having the potential to be affected by the same alleged deficient practice were identified and corrective action	11/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/06/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368		
(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>were observed being transported from the Main Kitchen to Unit C, the deserts placed on the trays were observed to be uncovered. There was construction work going on in the hallways leading from the kitchen to the unit. There was also construction work being performed on Unit C at the time of the delivery of the lunch trays.</p> <p>On 11/06/2014 2:15 p.m., interview with the Dietary Manager indicated the deserts should have been covered while being transported to the unit.</p> <p>3.1-21(i)(3)</p>		<p>was taken: Any resident who has their meal transported from the Main Kitchen to their unit has the potential to be affected by the alleged deficient practice. Staff educated on covering dessert plates on 11-6-14 for those transported to Unit-C.</p> <p>Measures that were put in place or what systemic change to ensure that the deficient practice does not recur: Staff to be educated on Sanitary conditions related to transporting trays from the main kitchen to the different units. Education to be completed by 11-21-14. How the corrective action will be monitored to ensure the deficient practice does not recur: Audit created - Exhibit B - Audit to be completed by Dietary Manager or Designee daily, five times a week x 8 weeks, then three times a week for x 8 weeks, then weekly x 2 months, then 2 x a month x 1 months. Compliance to be monitored by QAPI for trends/patterns until compliance is achieved. Date the systemic changes will be completed 11-28-14.</p>		