STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	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
F 0000 Bldg. 00	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00176471, IN00177742, IN00177395, and IN00177997 completed on July 16, 2015. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00179466, IN00180680, and IN00180886 completed on August 27, 2015 which cited an unrelated deficiency. This visit was in conjunction with the Investigation of Complaints IN00181613 and IN00181770. Complaint IN00176471- Not corrected Complaint IN00177742- Not corrected Complaint IN00177395- Not corrected Complaint IN00177997- Not corrected Survey dates: September 29 & 30, 2015 and October 1, 2015. Facility number: 000098 Provider number: 155187	F 0000	Submission of this Response and Plan of Corrections is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and Federal law that mandate submission of a plan of correction with ten (10) days of the survey as a condition of participation in the Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	AIM number: 100290980 Census bed type: SNF/NF: 146 Total: 146 Census payor type: Medicare: 26 Medicaid: 108 Other: 12 Total: 146 Sample: 13 These deficiencies reflect State findings cited in accordance with 410 IAC-16.2-3.1. Quality review completed by 26143, on October 8, 2015.			
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would			

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	indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to immediately report an allegation of abuse to the Executive Director and failed to thoroughly investigate an allegation of abuse, related to an allegation of resident to resident abuse for 1 of 3 abuse allegations/unusual occurrences reviewed. (Resident #H)	F 0225	It is the intent of this facility to ensure an injury of unknown origin for a dependent resident is thoroughly investigated. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The Executive Director self reported the allegation by Resident H immediately upon discovery during	10/15/2015

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	Finding includes: Resident #H's record was reviewed on 09/29/15 at 1:43. The resident's diagnoses included, but were not limited to chronic obstructive pulmonary disease and urinary tract infection. A Nurses' Progress Note, dated 09/13/15 at 2:12 p.m., indicated, "Resident was overheard by cna (sic) being verbally abusive to roommate. Resident rolled w/c (wheelchair) into b/r (bathroom) & began yelling @ (at) RM (roommate) for making a mess on the toilet & she wasn't going to clean it up anymore..." The note did not indicate the Executive Director was notified of the verbal abuse. A State Incident Report, dated 09/14/15, indicated the incident date was 09/13/15 at 2:14 p.m., "...Nurse noted in progress note that resident was overheard being verbally abusive to roommate..." The undated, unsigned investigation, indicated Resident #H's roommate had been interviewed and the resident indicated Resident #H had not said anything to her. There was no statement to indicate the CNA who had reported the abuse had been interviewed. There was no statement to indicated the Nurse who had documented the allegation of abuse		Clinical start-up meeting. Resident H's room mate was interviewed and the nurse was suspended pending an investigation. **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:** All residents have the potential of being affected by this alleged deficient practice. Resident documentation records were audited for any unreported allegations of abuse/neglect for 30 days prior to survey. Alert and oriented residents were interviewed about any unreported allegations of abuse. No other incidents were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff in-servicing on abuse/neglect/misappropriation will be conducted by the Executive Director/Director Nursing Services/Designee through 10/15/2015. DNS/ designee will review documentation to ensure allegations of abuse are completely and thoroughly investigated. Executive Director completed training on investigations. ED will review each report of allegations of abuse and will ensure they are completely and thoroughly investigated prior to sending final report to the Indiana	

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	had been interviewed. During an interview on 09/30/15 at 2:15 p.m., the Executive Director indicated the Nurse had not reported the allegation of abuse and the allegation was found when the staff were looking at the resident's progress notes. He indicated the investigation had been completed by the Director of Nursing, who was no longer employed at the facility. The Executive Director indicated he was the Abuse Coordinator. During an interview on 09/30/15 at 2:31 p.m., the Executive Director indicated the Social Service Director interviewed Resident #H's roommate and the roommate had not heard anything Resident #H had said, so the CNA had not been interviewed. This deficiency was cited on 07/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(c) 3.1-28(d)		Department of Health. The Executive Director will then audit self reports weekly to determine if allegations are isolated or becoming a trend. **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:** Audit results for compliance of reporting allegations of abuse will be reported in the QAPI meeting monthly for 6 months, then continuing as QAPI team determines necessary. **Date systemic changes will be completed:** 10/15/2015	

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F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting an allegation of abuse to the Executive Director and not thoroughly investigating an allegation of resident to resident abuse for 1 of 3 allegations of abuse/unusual occurrences reviewed. (Resident #H) Finding includes: Resident #H's record was reviewed on 09/29/15 at 1:43. The resident's diagnoses included, but were not limited	F 0226	It is the intent of this facility to ensure the Abuse Policy is followed related to staff reporting accurate information. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The Executive Director self reported the allegation by Resident H immediately upon discovery during Clinical start-up meeting. Resident H's room mate was interviewed and the nurse was suspended pending an investigation. **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:**	10/15/2015

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	to chronic obstructive pulmonary disease and urinary tract infection. A Nurses' Progress Note, dated 09/13/15 at 2:12 p.m., indicated, "Resident was overheard by cna (sic) being verbally abusive to roommate. Resident rolled w/c (wheelchair) into b/r (bathroom) & began yelling @ (at) RM (roommate) for making a mess on the toilet & she wasn't going to clean it up anymore..." The note did not indicate the Executive Director was notified of the verbal abuse. A State Incident Report, dated 09/14/15, indicated the incident date was 09/13/15 at 2:14 p.m., "...Nurse noted in progress note that resident was overheard being verbally abusive to roommate..." The undated, unsigned investigation, indicated Resident #H's roommate had been interviewed and the resident indicated Resident #H had not said anything to her. There was no statement to indicate the CNA who had reported the abuse had been interviewed. There was no statement to indicated the Nurse who had documented the allegation of abuse had been interviewed. During an interview on 09/30/15 at 2:15 p.m., the Executive Director indicated the Nurse had not reported the allegation of		All residents have the potential of being affected by this alleged deficient practice. Resident documentation records were audited for any unreported allegations of abuse/neglect for 30 days prior to survey. Alert and oriented residents were interviewed about any unreported allegations of abuse. No other incidents were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff in-servicing on abuse/neglect/misappropriation will be conducted by the Executive Director/Director Nursing Services/Designee through 10/15/2015. DNS/ designee will review documentation to ensure allegations of abuse are completely and thoroughly investigated. Executive Director completed training on investigations. ED will review each report of allegations of abuse and will ensure they are completely and thoroughly investigated prior to sending final report to the Indiana Department of Health. The Executive Director will then audit self reports weekly to determine if allegations are isolated or becoming a trend. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be**	

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	abuse and the allegation was found when the staff were looking at the resident's progress notes. During an interview on 09/30/15 at 2:31 p.m., the Executive Director indicated the Social Service Director interviewed Resident #H's roommate and the roommate had not heard anything Resident #H had said, so the CNA had not been interviewed. A facility policy, dated 01/06/15, titled, "Reporting Alleged Abuse Violation", received from the Director of Nursing as current on 09/30/15, indicated, "...Any employee who suspects an alleged violation immediately notifies the ED (Executive Director), or designee...The investigation includes interviews of employees...who may have knowledge of the alleged incident. Only factual information is documented...The documentation of the investigation is kept in the ED's office..." This deficiency was cited on 07/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(a)		**put into place:** Audit results for compliance of reporting allegations of abuse will be reported in the QAPI meeting monthly for 6 months, then continuing as QAPI team determines necessary. **Date systemic changes will be completed:** 10/15/2015	

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F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on observation, interview, and record review, the facility failed to ensure a resident with a pressure ulcer received necessary treatment and services to promote healing, related to a pressure area observed without a dressing applied as ordered by the resident's Physician for	F 0314	It is the intent of this facility to ensure necessary treatment and services are provided for residents with pressure ulcers, complete weekly skin assessments and initiate treatments for new pressure ulcers in a timely manner. **What corrective action(s) will be**	10/15/2015

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	1 of 3 resident's with pressure ulcers, in a total sample of 13. (Resident #K) Finding includes: During an observation on 09/29/15 at 12:28 p.m., Resident #K was lying in bed. The 100 Unit Manager, turned the resident onto her right side. The resident had a small open area noted on her right and left buttock. The area was superficial and pink in color. The 100 Unit Manager, indicated during the observation, the open area on the right buttock was almost healed. The open areas on the right and left buttock were not covered by a dressing. The 100 Unit Manager indicated the open areas did not have a dressing covering them. Resident #K's record was reviewed on 09/29/15 at 2:45 p.m. The resident's diagnoses included, but were not limited to, hypertension and dementia. A care plan, dated 09/24/15, indicated the resident had a pressure ulcer present on the right buttock. The interventions included, treatments as ordered. A Nurses' Progress Note, dated 09/24/15 at 7:57 p.m., indicated the resident had a stage 2 (superficial open area) to the right buttock, which measured 1 cm		**accomplished for those residents found to have been affected by the alleged deficient practice:** Resident K's dressing was immediately replaced on 9/29/15. **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:** All resident's have the potential of being affected by this alleged deficient practice. Residents with orders for wound dressing were checked to verify dressings were in place by the Unit managers on 9/29/2015. There were no other issues identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The unit managers/designee held small group in-servicing with licensed nursing staff on missing dressings and reporting on 9/29/15 through 10/5/2015. The Unit managers/ Designee will audit resident with orders for dressing to wound weekly for 4 weeks then randomly ongoing. The Director Nursing Services/Designee will complete 4 random audits weekly for 4 weeks.	

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	(centimeter) by 1 cm and had a stage 2 open area to the left buttock, which measured 2 cm by 2 cm. A Physician's Order, dated 09/24/15, indicated to cleanse the open areas to the right and left buttocks with wound cleanser, apply cavilon skin prep (skin barrier film), and then cover with a tegaderm hydocolloid dressing every (wound dressing) every third evening. The Medication Administration Record, dated 09/15, indicated the dressing had been applied on the evening of 09/28/15. During an interview on 09/29/15 at 3:37 p.m., the 100 Unit Manager indicated Resident #K should have had a dressing on the open areas on the buttocks. The 100 Unit Manager indicated she was unsure when the dressing had come off the resident. During an interview on 09/30/15 at 9:10 a.m., the 100 Unit Manager indicated she had interviewed the staff who had worked 09/28/15 on the evening and the night shifts and none of the staff were aware if the dressing was on or off of the resident's buttocks. She indicated she had spoke with the CNA's who had worked the morning of 09/29/15 and they were unaware of the dressing not being		Resident wound assessments and wound status will be reviewed weekly during clinical start-up meetings. **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:** Audit results of wound dressing changes will be reported in the QAPI meeting monthly for 6 months, then continuing as QAPI team determines necessary. **Date systemic changes will be completed:** 10/15/2015	

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	on the resident's buttocks. This deficiency was cited on 07/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-40(a)(2)			
F 0441 SS=D Bldg. 00	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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;			

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	(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure hand hygiene was performed and gloves were worn during the administration of an insulin injection, after the use of the glucometer, and between resident to resident contact for 1 of 2 residents observed for blood glucose monitoring in a sample of 13. (Residents # F and #S) (LPN #2) Finding includes:	F 0441	It is the intent of this facility to provide a sanitary environment to prevent the spread of infection related to cleaning precautions during the performance of routine testing of blood glucose levels. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The nurse completing the Accu- check on resident F completed the action. There were no adverse affects for this resident r/t the procedure. The nurse was asked by the surveyor to return to the	10/15/2015

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	On 9/301/5 at 11:20 a.m., LPN #2 was at the observed preparing to complete an glucometer (a finger stick of the resident's blood to obtain a blood sugar level). The LPN was at the in the hallway across from one of the Dining Rooms in the unit. The LPN put on a pair of disposable gloves, removed the glucometer and strips, and disinfectant wipes from the Medication Cart. The LPN wiped and wrapped the glucometer in a disinfectant wipe and carried the covered glucometer and test supplies down the hall and into the Resident #F's room. The LPN did not change gloves when she entered the resident's room The resident was laying in his bed. The LPN tested the resident's blood glucose from a finger on his right hand. The LPN did not remove the gloves she had on while performing the blood test. LPN #2 walked out of the resident's room with the glucometer and the used test strip while still wearing the same gloves. The LPN then walked back to the Medication Cart in the hallway, removed a wipe from the cart, wrapped the glucometer in the wipe, and placed the glucometer on the cart. LPN #2 removed her gloves. The LPN did not cleanse her hands with alcohol gel or wash her hands		medication cart before completing an Accu-check for resident S. There were no adverse affects for this resident. **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:** All residents have the potential of being affected by this alleged deficient practice. The nurse was immediately re-educated on infection control guidelines including hand washing on 9/30/2015 by the Unit manager. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** On 9/30/2015 the Unit managers/Director Nursing Services/Designee immediately started re-education with staff on Infection control/handwashing. Infection control/handwashing guidelines were also included in facility Fireside Chats led by the Executive Director and the Director Nursing Services on 10/5/2015. The Director Nursing Services/ Designee will observe handwashing demonstrations 5 times per week for 4 weeks on clinical staff then random employee observations will be done monthly by department managers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	155187	A. BUILDING 00 B. WING	10/01/2015

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	after she removed her gloves. The LPN then signed out the glucometer test results on the computer attached to the Medication Cart. LPN #2 then removed a vial of insulin and a syringe from the Medication Cart and prepared a dose of insulin for Resident #F. The resident was standing next to the Medication Cart and he picked up his shirt and requested the LPN administer the insulin in his abdomen. LPN #2 injected the insulin into the right side of the resident's abdomen. The LPN did not wear gloves while injecting the insulin. The LPN then placed the insulin vial back into the Medication Cart, removed the disinfectant wipe from the glucometer, and threw the wipe away. The LPN then went into the bathroom in the small Dining Room on the unit and obtained a new pair of disposable gloves and returned to the Medication Cart. The LPN picked up the glucometer and test strips and entered the large Dining Room. LPN #2 then approached Resident #S and informed the resident she was going to test her blood sugar. The LPN put on the new pair of gloves and removed a test strip from the bottle and placed her hand on the resident's hand. The LPN was requested to return to the Medication Cart		**assurance program will be put into place:** Trends and patterns of deviation from guidelines of Infection control/hand washing will be reviewed during monthly QAPI monthly for 6 months, then continuing as QAPI team determines necessary. **Date systemic changes will be completed:** 10/15/2015	

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	prior to performing the accucheck for Resident #S. When interviewed at this time, the LPN indicated the facility policy was to wear gloves for injection and to wash hands between residents. The LPN indicated she thought that was not necessary during the above observation since she was "wearing gloves." The record for Resident #F was reviewed on 10/1/15 at 10:35 a.m. The When interviewed on 9/30/15 at 11:40 a.m., Unit Manager #2 indicated hand washing was to be completed after removing gloves and between resident to resident care. The facility policy titled " Handwashing/Hand Hygiene" was reviewed on 9/30/15 at 12:05 p.m. The policy had a revised date of August 2014. The Interim Director of Nursing provided the policy and indicated the policy was current. The policy indicated hand hygiene was to be performed before and after direct contact with residents, before preparing or handling medications, after contact with a resident's intact skin, after contact with objects such as medical equipment in the vicinity of the resident, and after removing gloves. The policy			

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	also indicated disposable gloves were to be worn before aseptic procedures and when anticipating contact with blood or body fluids. This deficiency was cited on 07/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1- 18(l)			