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	07/28/2016

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 Investigation of Complaints IN00205091 and IN00205181. This visit was in conjunction with the PSR (Post Survey Revisit) to the investigation of Complaints IN00201888 and IN00202155 completed on June 29, 2016. Complaint IN00205091- Substantiated. Federal/State deficiencies related to the allegations are cited at F312, F327 and F353. Complaint IN00205181- Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, F281, F282, F312, F332, F333, F353, and F514. Survey dates: July 26, 27 & 28, 2016 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census bed type: SNF/NF: 146 Total: 146 Census payor type:	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in 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 The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Jason Eastlund, BSW, HFA	

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

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	07/28/2016

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
	Medicare: 25 Medicaid: 103 Other: 18 Total: 146 Sample: 21 These deficiencies reflects State findings in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 8/1/16.			
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 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.			

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	07/28/2016

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
	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 report an allegation of abuse to the Indiana State Department of Health (ISDH), related to an observation of sexual conduct of two cognitively impaired residents for 1 of 3 allegations of abuse reviewed. (Residents #G and #S). Finding includes: Resident #G's record was reviewed on 07/26/16 at 1:30 p.m. The resident's	F 0225	FountainviewPlace ensures that all alleged violations involving mistreatment, neglect orabuse, including injures of unknown source and misappropriation of residentproperty are reported immediately to the administrator of the facility and toother officials TheExecutive Director self reported the incident between resident G and S on8/9/16. Allresidents have the potential to be affected by the alleged deficient practice.Employee and resident interviews were conducted to ensure that all alleged violationswere reported to	08/25/2016

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	07/28/2016

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
	diagnoses included, but was not limited to, dementia. A Significant Change Minimum Data Set assessment (MDS), dated 05/24/16, indicated the resident's cognition score was a 10 (8-12 indicates moderately impaired) and required extensive assistance with transfers and locomotion. A care plan, dated 04/03/16 indicated the resident had impulsive behavior of making inappropriate gestures and statements to others. The interventions included, one on ones as needed and behavior checks initiated 04/02/16. A care plan, dated 04/13/16, indicated the resident demonstrated sexually inappropriate behaviors - inappropriate touching, sexual comments, groping, getting into bed with others and luring others to the room. The interventions included, one on ones as needed and behavior checks as needed, initiated 04/13/16. A Nurses' Note, dated 06/29/16 at 9:15 p.m., indicated the resident was found in her own bed with another resident, fully clothed. The other resident was on top of Resident #G with a blanket between the residents. The note indicated Resident #G stated, "we were pretend making		ISDH. No findings were noted. Staffin-service on abuse/neglect/misappropriation was conducted by the ExecutiveDirector/Designee prior to date of compliance. The ED will review eachallegation of abuse and ensure they are thoroughly investigated prior tosending a final report to ISDH. ED/Designeeto complete 5 random abuse audits weekly for 1 month, then 5 random abuseaudits monthly for 3 months; And then quarterly there after until 95%compliance is achieved. Results will be submitted to QAPI for review toensure compliance Date of compliance: 8/25/16	

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	07/28/2016

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
	love." Resident #S's record was reviewed on 07/27/16 at 11:30 a.m. The resident's diagnoses included, but were not limited to, dementia and Alzheimer's disease. The Quarterly MDS assessment indicated the resident's cognition score was an 8 (8-12 indicates moderately impaired), required limited assistance with transfers and ambulation, and sometimes understood communication. A care plan, dated 09/18/14, indicated the resident demonstrated sexually inappropriate behaviors - inappropriate touching, groping, and had gotten into bed with others. The interventions included, if inappropriate behavior, quietly attempt to re-direct, remind behavior is not appropriate. A Nurses' Note, dated 06/29/16 at 9:15 p.m., indicated the resident was found on top of another resident in the other resident's bed. The resident was fully clothed with a blanket between residents. The resident was asked what he was doing and he stated, "I was a bad boy." During an interview on 07/27/16 at 10:25 a.m., the Administrator indicated the incident was not reported to the ISDH.			

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	07/28/2016

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
	During an interview on 07/27/16 at 11:08 a.m., the Social Service Director (SSD)the incident was not reported because the resident both wanted to engage in "some form of love making, it was not aggressive." The SSD indicated the residents were in the earlier stage of dementia with her cognition score of a 10 and his an 8 and neither resident were affected negatively. She indicated they considered the incident as behaviors. The Administrator indicated both residents had similar cognition scores and both consented to the incident and there had been no contact. The SSD indicated the staff notified the Administrator. During an interview on 07/27/16 at 12:25 p.m., LPN #3 indicated both residents were last seen approximately 30 minutes prior to the incident, Resident #G was in bed and Resident #S was in his room. LPN #3 indicated she had notified the Administrator immediately. LPN #3 indicated it was the policy to call the Administrator to discuss if the incident was abuse. This Federal Tag relates to Complaint IN00205181. 3.1-28(c)			

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	07/28/2016

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 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 follow the facility's policy for reporting to the Indiana State Department of Health (ISDH) of an observation of sexual conduct of two cognitively impaired residents, for 1 of 3 abuse allegations reviewed. (Residents #G and #S) Finding includes: Resident # G's record was reviewed on 07/26/16 at 1:30 p.m. The resident's diagnoses included, but were not limited to, dementia. A Significant Change Minimum Data Set assessment (MDS), dated 05/24/16, indicated the resident's cognition score was a 10 (8-12 indicates moderately impaired) and required extensive assistance with transfers and locomotion.	F 0226	FountainviewPlace ensures that all alleged violations involving mistreatment, neglect orabuse, including injures of unknown source and misappropriation of residentproperty are reported immediately to the administrator of the facility and toother officials TheExecutive Director self reported the incident between resident G and S on8/9/16. All residents have the potential to be affected by the alleged deficient practice.Employee and resident interviews were conducted to ensure that all alleged violationswere reported to ISDH. No findings were noted. Staffin-service on abuse/neglect/misappropriation was conducted by the ExecutiveDirector/Designee prior to date of compliance. The ED will review eachallegation of abuse and ensure they are thoroughly investigated prior tosending a final report to ISDH. ED/Designeeto complete 5 random abuse audits weekly for 1 month, then 5 random	08/25/2016

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	07/28/2016

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
	A care plan, dated 04/03/16 indicated the resident had impulsive behavior of making inappropriate gestures and statements to others. A care plan, dated 04/13/16, indicated the resident demonstrated sexually inappropriate behaviors - inappropriate touching, sexual comments, groping, getting into bed with others and luring other to the room. A Nurses' Note, dated 06/29/16 at 9:15 p.m., indicated the resident was found in her own bed with another resident, fully clothed. The other resident was on top of Resident #G with a blanket between the residents. The note indicated Resident #G stated, "we were pretend making love." Resident #S's record was reviewed on 07/27/16 at 11:30 a.m. The resident's diagnoses included, but were not limited to, dementia and Alzheimer's disease. The Quarterly MDS assessment indicated the resident's cognition score was an 8 (8-12 indicates moderately impaired), required limited assistance with transfers and ambulation, and sometimes understood communication. A care plan, dated 09/18/14, indicated the		abuseaudits monthly for 3 months; And then quarterly there after until 95%compliance is achieved. Results will be submitted to QAPI for review toensure compliance Date of compliance: 8/25/16	

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	07/28/2016

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
	resident demonstrated sexually inappropriate behaviors - inappropriate touching, groping, and had gotten into bed with others. A Nurses' Note, dated 06/29/16 at 9:15 p.m., indicated the resident was found on top of another resident in the other resident's bed. The resident was fully clothed with a blanket between residents. The resident was asked what he was doing and he stated, "I was a bad boy." During an interview on 07/27/16 at 10:25 a.m., the Administrator indicated the incident was not reported to the ISDH. During an interview on 07/27/16 at 11:08 a.m., the Social Service Director (SSD)the incident was not reported because the resident both wanted to engage in "some form of love making, it was not aggressive." The SSD indicated the residents were in the earlier stage of dementia with her cognition score of a 10 and his an 8 and neither resident were affected negatively. She indicated they considered the incident as behaviors. The Administrator indicated both residents had similar cognition scores and both consented to the incident and there had been no contact. The SSD indicated the staff notified the Administrator.			

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	07/28/2016

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
	During an interview on 07/27/16 at 12:25 p.m., LPN #3 indicated both residents were last seen approximately 30 minutes prior to the incident, Resident #G was in bed and Resident #S was in his room. LPN #3 indicated she had notified the Administrator immediately. LPN #3 indicated it was the policy to call the Administrator to discuss if the incident was abuse. A facility policy, titled, "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation", dated 01/2016 and received as current from the Administrator, indicated, "...Sexual abuse includes, but is not limited to: sexual harassment, sexual coercion, sexual assault...Reporting of suspected alleged violations is required by all staff. Incidents of alleged violations are reviewed by the center's Quality Assurance and Performance Improvement Committee for detection of patterns or trends...Staff must report the suspicion of an incident to the Executive Director, Director of Nursing, or supervisor. The ED (Executive Director) notifies the appropriate state agency in accordance with state law..." This Federal Tag relates to Complaint IN00205181.			

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	07/28/2016

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
	3.1-38(a)			
F 0281 SS=D Bldg. 00	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, record review, and interview the facility failed to ensure professional standards of quality were followed related to a Nurse signing for an administration of an insulin injection when the Nurse herself did not administer the insulin, for 1 of 3 residents observed for medication administration in a sample of 21. (Resident #H) Finding includes: During a morning medication administration observation on 07/26/16 from 9:05 thru 9:20 a.m., LPN #1 prepared Resident #H's morning medication. LPN #1 indicated she could not find the resident's Levemir insulin in the Medication Cart and would have to get the insulin from the Emergency Drug	F 0281	Itis the intent of this facility to ensure that professional standards of qualitycare are met. 281 Itis the intent of this facility to ensure that professional standards of qualitycare are met. ResidentH had physician notified regarding the medication error. Patient was observedfor signs and symptoms of negative consequences with no findings Allother residents who receive insulin were reviewed prior to date of compliance,by the DON/Designee, to ensure appropriate dosage and times were being followedper physician order. Educationwas provided by DON/Designee to licensed nurses in regards tomedication pass policy and procedure, prior to date of compliance.	08/25/2016

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	07/28/2016

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
	Kit (EDK). LPN #1 then administered Resident #H's oral medication and explained to the resident she would have to obtain the insulin from the EDK and would be back to administer the insulin. LPN #1 then indicated the Unit Manager was obtaining the Levemir insulin from the EDK. During an interview on 07/26/16 at 10:40 a.m., LPN #1 indicated the Levemir had not been given yet and the insulin had to be ordered stat (immediately) from the Pharmacy. During an interview on 07/26/16 at 10:45 a.m., the Director of Nursing (DON), indicated the Night Shift Nurses had stayed over and helped out the Day Shift Nurses and the resident had received the Levemir insulin before breakfast. The DON indicated the insulin had not been signed off as given by the Night Shift Nurses and LPN #1 had not known the Night Shift Nurses had administered the insulin. The Medication Administration Record (MAR), dated 07/2016, indicated by signed initials of LPN #1, the Levemir 46 units, scheduled for 8 a.m., had been administered to the resident at 10:42 a.m. During an interview on 07/26/16 at 10:50		DON/Designeewill audit 5 resident medication passes per week X 1 month then 5 residents permonth X 3 months and then quarterly until 95% compliance is achieved. Medicationpass audits will occur randomly on all shifts. All negative findings willbe reviewed in monthly QUAPI meeting. Dateof compliance 8.25.16	

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	07/28/2016

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
	a.m., LPN #1 indicated she knew the insulin had been given by the Night Shift Nurses. LPN #1 indicated she did not give the insulin, but saw the insulin given so she signed the insulin had been administered. Resident #H's record was reviewed on 07/26/16 at 1 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus, hypertrophy of prostate, and esophageal reflux. The Quarterly Minimum Data Set assessment, dated 06/29/16, indicated the resident's cognition was moderately impaired. A Physician's Order, dated 07/01/16, indicated Levemir insulin, 46 units subcutaneously daily. During an interview with Resident #H, on 07/26/16 at 1:15 p.m., he indicated he could not remember if the insulin was given. During an interview on 07/26/16 at 2 p.m., the Administrator indicated the Nurse who administered the insulin should have signed the insulin out as given at that time. During an interview on 07/26/16 at 2:45			

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	07/28/2016

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
	p.m., LPN #1 indicated she saw the Night Shift Nurse drawing up the insulins on that hallway for administration and had over-heard the Nurses talking. LPN #1 indicated she was told all blood sugars and insulins were administered by the Night Shift Nurses. LPN #1 indicated when she was preparing Resident #H's morning medications, the E-MAR (Electronic Medication Administration Record) indicated the Levemir had not been given and she had thought the Night Nurses had not given the Levemir, then thought they would have told her if they had not given the insulin. LPN #1 indicated she had not seen Resident #H's Levemir given by the Night Nurses and had signed the E-MAR with her initials indicating the insulin had been administered. A Professional Resource, titled, "Indiana State Board of Nursing" 2008 Edition, title 848 Indiana Administrative Code 848 IAC 2-3-3, indicated, "...Nursing behaviors...failing to meet the minimal standards of acceptable and prevailing licensed practical nursing practices, which could jeopardize the health, safety, and welfare...These behaviors shall include, but are not limited to...(1) Using unsafe judgement, technical skills...(6) Falsifying...documentation of nursing actions on the official patient/client			

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	07/28/2016

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
	record..." A facility policy, dated 06/2015, titled, "Medication Administration-General Guidelines", received from the Administrator as current, indicated, "...The individual who administers the medication dose records the administration on the resident's MAR..." This Federal Tag relates to Complaint IN00205181. 3.1-35(g)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow Physician's Orders and care plans, related to laboratory (lab) tests and insulin administration for 3 of 12 residents reviewed for Physician's Orders and care plans in a sample of 21. (Residents #D, #M, and #P)	F 0282	It is the intent of this facility to ensure that physician orders, including labs and medication administration, are followed as prescribed. ResidentD had UA and urine protein lab obtained on 7.20.16 Residents M and P had physician notified related to medication error on7.26.16, 8.11.16 and were observed for signs and symptoms of	08/25/2016

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	07/28/2016

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
	Findings include: 1. Resident #D's record was reviewed on 07/27/16 at 9:40 a.m. The resident's diagnoses included, but were not limited to, hypertension, urinary retention and chronic urinary tract infections. A care plan, dated 03/30/16, indicated the resident had an indwelling urinary catheter and was at risk for urinary tract infections. The interventions included labs as ordered. A Physician's Order, dated 06/23/16, indicated to check urine protein due to hypertension and to obtain a urinalysis with culture and sensitivity. The results of the urine protein, urinalysis with culture and sensitivity were not located in the resident's record. The Nurses' Progress Notes, dated 06/23/16 through 06/26/16 had not indicated a urine for protein and urinalysis with culture and sensitivity had been sent to the Lab for testing. During an interview on 07/27/16 at 1:15 p.m., the B-Unit Manager indicated the urine lab tests had not been done. She indicated she notified the Lab Company and they had not received the urine for		negativeconsequences, with no findings All physician orders/plans of care, including, residents who receive insulin andhave UA orders were reviewed prior to date of compliance, by the DON/Designee,to ensure appropriate dosage, times and orders were being followed. Education was provided by DON/Designee to licensed nurses and completedprior to date of compliance, regarding lab and medication pass policy andprocedure DON/designeewill audit 5 medication passes, to include all physician orders, and 5 laborders per week X 1 month then 5 medication passes and 5 lab orders per month X3 month then 5 medication passes and 5 lab orders per quarter until 95%compliance is achieved All negative findings will be reviewed in monthly QUAPImeeting Dateof compliance 8-25-16	

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	07/28/2016

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
	testing. 2. Resident #M's record was reviewed on 07/26/16 at 3:20 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and dementia. A care plan, dated 06/29/16, indicated the resident had an alteration in blood glucose due to diabetes mellitus. The interventions included, administer medications as ordered. A Physician's Order, dated 02/21/16, indicated Novolog insulin, administer amount per blood sugar result (sliding scale), scheduled for 8 a.m., 12 p.m., and 4 p.m. The Medication Administration Record (MAR), dated 07/2016, indicated the resident's blood sugar on 07/26/16 at 8 a.m. was 325 and the sliding scale Novolog insulin of 8 units was given at 10:40 a.m. During an interview on 07/26/16 at 10:25 a.m., the B-Unit Manager indicated the residents had breakfast between 8 a.m. and 8:30 a.m. and would have lunch between 11 a.m. and 11:30 a.m. A Professional Resource, "Nursing 2014 Drug Handbook", page 748, indicated,			

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	07/28/2016

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
	"NovoLog...Give NovoLog 5 to 10 minutes before start of meal..." 3. Resident #P's record was reviewed on 07/26/16 at 3:20 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypothyroidism. A Physician's Order, dated 11/30/16, indicated Lantus insulin 112 units daily. The MAR, dated 07/2016, indicated the Lantus insulin was to be given at 8 a.m. The MAR indicated on 07/26/16, the resident's Lantus was administered at 11:23 a.m. During an interview on 07/26/16 at 3:20 p.m. the B-Unit Manager indicated the insulin doses were given late. A Professional Resource, titled, "Nursing 2014 Drug Handbook", page 753, indicated, "Lantus...give subcutaneously once daily at the same time each day..." A facility policy, dated 06/2015, titled, "Medication Administration-General Guidelines", received from the Administrator as current, indicated, "...Medications are administered within [60 minutes] of scheduled time...Unless otherwise specified by the prescriber..." This Federal Tag relates to Complaints			

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	07/28/2016

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
	IN00205181. 3.1-35(g)(2)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to provide assistance with ADLs (Activities of Daily Living) related to nail care not provided	F 0312	It is the intent that this facility ensure ADL care is provided to all residentswho are in need of assistance. ResidentC's nails were cleaned on 7/27/16 at 3:45pm and verified	08/25/2016

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	07/28/2016

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
	for 1 of 3 residents reviewed for ADLs in a sample of 21. (Resident #C) Finding includes: On 7/26/16 at 10:08 a.m., CNA #4 was observed pushing Resident #C in her wheelchair down the hall. The CNA left the resident against the wall in front of the Nursing Station. The resident was able to open her left hand. There was an accumulation of light brown colored substance under four of the resident's nails. The resident was not able to open her right hand upon command. On 7/27/16 at 7:40 a.m., the resident was observed in the hallway across from the Nursing Station. The resident's finger nails on her left hand were dirty. The resident was taken to the Main Dining Room at 7:42 a.m. The resident was placed at table with another female resident. The resident's finger nails had not been cleaned. The resident was served her breakfast tray at 8:30 a.m. and staff assisted the resident in cutting up her food. On 7/27/16 at 12:15 p.m., the resident was observed at table in the Main Dining Room waiting for lunch. The resident's left hand fingernails had not been cleaned.		by the ExecutiveDirector. Awhole house audit regarding resident nail condition was conducted on8/2/16. All findings were resolved upon identification Alllicensed staff were educated in regards to ADL care, including nail care, byDON/Designee prior to date of compliance. DNS/Designeewill audit ADL care on 5 resident per week for 1 month then 5 residents monthlyfor 3 months then 5 residents quarterly until 95% compliance is achieved. Anynegative findings will be discussed in monthly QUAPI meetings. Dateof Compliance: 8.25.16	

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	07/28/2016

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

On 7/27/16 at 2:35 p.m., the resident was observed in bed. The resident's left hand fingernails remained dirty. No staff members were in the resident's room.

The record for Resident #C was reviewed on 7/27/16 at 12:30 p.m. The resident's diagnoses included, but were not limited to, anemia, cerebral infarct (stroke), abdominal pain, atrial fibrillation (an irregular heart rhythm), and depressive disorder.

Review of the 5/2/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). A score of (11) indicated the resident's cognitive patterns were moderately impaired. The MDS assessment indicated the resident required extensive assistance of one staff member for dressing and personal hygiene. The assessment indicated the resident was dependent on one staff member for bathing. The assessment indicated the resident had impairment in range of motion on both of her upper and both of her lower extremities

The resident's current Care Plans were reviewed. A Care Plan initiated on 11/26/14 indicated the resident required assistance with ADLs (Activities of

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	07/28/2016

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
	Daily Living) due to hemiplegia (limitation in movement caused by a stroke). The Care Plan was last updated with a target Goal Date of 8/31/16. Care Plan interventions included, but were not limited to, provide verbal cues and encouragement to use to use her left hand as much as possible and assist resident as needed. When interviewed on 7/27/16 at 3:40 p.m., the facility Administrator indicated care should have been provided for the resident's nails. When interviewed on 7/27/16 at 2:40 p.m., the Nursing Unit Manager indicated no staff had reported any behaviors or refusals of care during the day shift. This Federal tag related to Complaints IN00205181 and IN00205091. 3.1-38(a)(2)(D)			
F 0327 SS=D Bldg. 00	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview,	F 0327	Itis the intent of this facility to	08/23/2016

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	07/28/2016

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
	the facility failed to complete resident assessments and monitor fluid intake to ensure the resident's fluid intake was meeting the resident's need to prevent dehydration for 1 of 3 residents reviewed for hydration in a sample of 21. (Resident #B) Finding includes: The closed record for Resident #B was reviewed on 7/27/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to, dementia, heart failure, altered mental status, major depressive disorder, and chronic obstructive pulmonary disease. Review of the 5/13/16 MDS (Minimum Data Set) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (10). A score of (10) indicated the resident's cognitive patterns were moderately impaired. The assessment indicated the resident required extensive assistance of one staff member for eating, dressing, and personal hygiene. The assessment indicated the resident was frequently incontinent of bowel and bladder. The MDS assessment indicated the resident received a diuretic medication (3) days in the (7) day reference period.		ensure that all resident hydration needs aremet. ResidentB was discharged on 6/23/16 Allresidents had a hydrations status review completed prior to date of complianceby the DON/Designee. Alllicensed staff were educated related to the hydration policy andprocedure, prior to date of compliance. DON/Designeeto audit hydration on 5 residents per week X 1 month, 5 residents per month X 3months and 5 residents quarterly until 95% compliance is achieved, any negativeconsequences will be reviewed in monthly QUAPI meeting Dateof compliance 8/27/16	

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	07/28/2016

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
	Review of the 6/2016 Order Summary Report indicated there was a Physician order for the resident to receive Lasix (a diuretic medication) 20 milligrams one time a day every other day. The order was originally written on 9/9/2014. The resident's Care Plans were reviewed. A Care Plan initiated on 11/11/15 indicated the resident was a Nutritional Risk related to a low BMI (Body Mass Index), difficulty chewing, a history of significant weight loss, and required a mechanically altered diet. The Care Plan was lasted update with a target goal date of 6/30/16. Care Plan interventions included, but were not limited to , provide mechanically altered diet, monitor meal consumption daily, and monitor weight per the facility policy. A Care Plan initiated on 9/24/14 indicated the resident had an alteration in Hydration related to Diuretic use. The Care Plan goal was for the resident to remain free of signs and symptoms of dehydration. The Care Plan was last updated with a target goal date of 8/31/16. Care Plan interventions included, but were not limited to, observe the appearance of mucous membranes and skin turgor, and observe for side effects of diuretic use.			

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	07/28/2016

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
	The 5/2016 Progress Notes were reviewed. An RD note was completed by the RD on 5/27/16. This entry indicated the resident had an unplanned weight loss and her average oral intake was 37% of meals consumed in last seven days. There were no assessment of the resident's mucous membranes or fluid intakes for 5/2016. The 6/2016 Progress Notes were reviewed. An RD note was completed on 6/6/16. This note indicated the resident had a weight loss. Current interventions were to be continued. There were no assessments of the resident's oral intakes or skin turgor, or mucous membranes in the June Nursing Progress Notes. A RD note was completed on 6/17/16. This note indicated the resident had weight loss noted in the last week and the resident oral intakes averaged 20% of meals in the past seven days. Interventions included to encourage oral intakes. Review of the 6/2016 Group Meal Report for Resident #B indicated the resident's meal intakes for 6/1/16 to 6/23/16 were recorded. The resident consumed 33% of her breakfast meal, 14% of her lunch meals 38% of her dinner meals, 31% of her evening snack. The report did not			

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	07/28/2016

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
	specify the amount of fluids the resident consumed with each meal or snack. The resident received two supplements and the intake of those supplements was recorded. There was no other record of the resident's fluid intakes. A Nursing Note was completed on 6/23/16 at 8:02 p.m. This entry indicated the resident was admitted to the hospital with a diagnosis of dehydration. Laboratory tests indicated the resident BUN and Creatinine were high. The residents BUN was 93 (normal 7 - 22), Creatinine level was 2.69 (normal 1.0 - 2.0), and Sodium level was 165 (normal 135 - 147). When interviewed on 7/27/16 at 3:45 p.m., the facility Administrator indicated resident's oral meal consumption were documented. The Administrator indicated there was no documentation of the resident's fluid intake being monitored. The facility Administrator indicated the resident had a Care Plan in place related to being at risk for dehydration related to the use on diuretics and no ongoing assessment of the resident's hydration status. The facility Administrator indicated the resident was admitted to the hospital on 6/23/16 with elevated BUN and Creatinine levels indicating dehydration.			

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	07/28/2016

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
	This Federal tag relates to IN00205091. 3.1- 46(b)			
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 3 residents observed during 2 medication pass observations; 8 errors in medications were observed during 27 opportunities for errors in medication administration. This resulted in a medication error rate of 29.62%. (Residents #H and #J) Findings include: 1. During a morning medication	F 0332	It is the intent of the facility to ensure that medications are given on time andas ordered per the physician. 332 Itis the intent of the facility to ensure that medications are given on time andas ordered per the physician. Facilitycontacted the pharmacy related to resident H on 7.26.16 and medication wasgiven upon getting to facilityResident J had physician notified regarding the medication error on 7.26.16.Patient was observed for signs and symptoms of negative	08/25/2016

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	07/28/2016

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
	administration observation on 07/26/16 from 9:05 thru 9:20 a.m., LPN #1 prepared Resident #H's morning medication, which included Multivitamin, Quinapril HCL (antihypertensive) 5 mg (milligrams), famotidine (stomach medication) 20 mg, docusate sodium (stool softener) 100 mg, and paroxetine (antidepressant) 10 mg. LPN #1 placed the five medications in the plastic cup, then opened up two single packages, which were marked as evening. One package contained famotidine 20 mg and one package contained tamsulosin (prostate medication) 0.4 mg. LPN #1 indicated the ipratropium 0.02% (breathing medication given with nebulizer) could not be given because she could not find the medication to administer to the resident. During an interview on 07/26/16 at 9:20 a.m., LPN #1 indicated she was ready to give Resident #H the medications. LPN #1 was stopped prior to the administration. LPN #1 re-checked the medications in the medication cup and containers and acknowledged two doses of famotidine 20 mg were in the medication cup and a dose of tamsulosin 0.4 mg was in the medications cup. LPN #1 indicated the second dose of famotidine and the tamsulosin were to be		consequences, with nofindings DON/Designeereviewed all residents with breathing treatments and insulin orders to ensuremedications were administered per physician order. Education was provided to licensed nurses by DON/Designee priorto date of compliance, related to medication pass policy and procedures DON/Designeeto audit 5 medication passes per week X 1 month then 5 medications permonth X 3 months, then quarterly there after until 95% compliance is achieved. Medicationpass audits will occur randomly on all shifts. Any negative findingswill be reviewed in the monthly QUAPI meetings. Dateof compliance 8/25/16	

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	07/28/2016

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
	given in the evening. During an interview on 07/26/16 at 11:25 a.m., LPN #1 indicated she had not administered the ipratropium as ordered to Resident #H. Resident #H's record was reviewed on 07/26/16 at 1 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus, hypertrophy of prostate, chronic obstructive pulmonary disease, and esophageal reflux. The Physician's Recapitulation Orders, dated 07/2016, included orders for tamsulosin, give 0.4 mg at bedtime, ipratropium 0.02%, inhale orally every four hours, and famotidine, give 20 mg twice a day. 2. During an observation on 07/26/16 at 10:25 a.m., the B-Unit Manager prepared Resident #J's 8 a.m. medications, which included Coreg (heart medication) 25 mg, hydralazine (antihypertensive) 100 mg, and Novolog insulin 5 units. The B-Unit Manager administered the medication to Resident #J. During an interview at the time of the observation, the B-Unit Manager indicated the Nurse assigned to the resident's hall was passing medications			

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	07/28/2016

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
	on another hall and was "behind" in the medication pass. She indicated the resident's breakfast was served between 8 a.m. and 8:30 a.m. During an interview at the time of the observation, Resident #J indicated she had checked her own blood sugar before she ate breakfast and it was 200 and she had not had her morning insulin yet. Resident #J's record was reviewed on 07/26/16 at 1:25 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus, hypertension, and congestive heart failure. The Quarterly Minimum Data Set assessment, dated 06/26/16, indicated the resident's cognition was intact. The Physician's Orders, indicated Coreg 25 mg, give one tablet two times daily and was scheduled for 8 a.m. and 4 p.m., hydralazine 100 mg, give one tablet three times daily and was scheduled for 8 a.m., 12 p.m., and 4 p.m., and Novolog, inject per sliding scale (units per blood sugar result), 151-200 blood sugar, give 5 units subcutaneously before meals. A facility policy, dated 06/2015, titled, "Medication Administration-General Guidelines", received from the			

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	07/28/2016

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
	Administrator as current, indicated, "...Medications are administered within [60 minutes] of scheduled time...Unless otherwise specified by the prescriber..." This Federal Tag relates to Complaints IN00205181. 3.1-25(b)(9) 3.1-48(c)(1)			
F 0333 SS=D Bldg. 00	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure residents remained free of significant medication errors related to an anticoagulant medication given after being discontinued, not given when ordered, not given as ordered, and gastrointestinal medications not given at meal time as per the Physician order and medication recommendations for 2	F 0333	Itis the intent of this facility to ensure that medications are given asprescribed by the physician. 333 Itis the intent of this facility to ensure that medications are given asprescribed by the physician. ResidentC had physician notified related to Coumadin medication error, Resident E hadphysician notified related to Protonix medication error. Residents wereobserved for signs and	08/25/2016

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	07/28/2016

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
	residents reviewed for or observed during the administration of medications in a sample of 21. (Residents #C and #E) Findings include: 1. The record for Resident #C was reviewed on 7/27/16 at 12:30 p.m. The resident's diagnoses included, but were not limited to, anemia, cerebral infarct (stroke), abdominal pain, atrial fibrillation (an irregular heart rhythm), and depressive disorder. Review of the 5/2/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). A score of (11) indicated the resident's cognitive patterns were moderately impaired. The MDS assessment indicated the resident had received anticoagulant medication (5) days during the assessment reference period of (7) days. The resident's current Care Plans were reviewed. A Care Plan initiated on 5/16/13 indicated the resident was at risk for complications related to the use of anticoagulant medications due to atrial fibrillation and a history of a stroke. The Care Plan was last updated with a goal date of 8/31/16. Care Plan interventions included, but were not limited to, monitor		symptoms of negative consequences with no findings. Allother Residents who have orders for Coumadin and medications prior to meals werereviewed by DON/Designee, to ensure orders are being followed prior to date ofcompliance Educationwas provided on medication pass to licensed nurses by DON/Designee prior todate of compliance. DON/Designeeto audit 5 medication passes per week X 1 month then 5 medications permonth X 3 months, then quarterly there after until 95% compliance is achieved. Medicationpass audits will occur randomly on all shifts. Any negative findings will be reviewed in themonthly QUAPI meetings. Dateof compliance 8/25/16	

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	07/28/2016

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
	the resident's medication regime, report abnormalities to the Physician, and monitor the resident for bruising. The June 2016 Physician orders for Laboratory tests were reviewed. The following orders were as noted: 6/16/16 - PT/INR to be completed on 6/23/16. 6/23/16 - PT/INR to be completed on 6/29/16. 6/30/16 - PT/INR to be completed on 7/13/16. The 6/2016 PT/INR Laboratory test results and Physician orders were as noted: 6/22/16 PT: 76.5 (reference range: 9.1-12.5) INR: 6.2 (reference range: 0.9-1.2) 6/23/16 PT: 40.5 INR: 3.4 A Physician's order was written on 6/23/16 to administer Coumadin (an anticoagulant medication) 5 milligrams every evening until 6/29/16. 6/29/16 PT: 20.1 INR: 1.8 6/30/16			

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	07/28/2016

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
	PT: 21.6 INR: 1.9 No Physician orders for Coumadin doses were noted on 6/30/16. The 6/2016 Medication Administration Record was reviewed. The resident did not receive any Coumadin on 6/30/16. The 7/2016 Physician orders were reviewed. An order was written on 7/13/16 for the resident to receive Coumadin 2.5 milligrams every Sunday evening. The order also indicated the resident was to receive Coumadin 5 milligrams in the evening on Mondays, Tuesdays, Wednesdays, Thursdays, Fridays, and Saturdays. The 7/2016 Medication Administration Record was reviewed. The resident did not receive any Coumadin medication 7/1/2016 through 7/12/16. Review of the 7/2016 Nursing Progress Notes indicated there was no documentation of Coumadin being administered between 7/1/16 and 7/12/16. There was no documentation of any attempts to contact the Physician for further orders for the administration of Coumadin. Review of the "INR/PT Flow Sheet"			

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	07/28/2016

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
	indicated the there was only one entry completed in 6/2016. This entry was made on 6/16/16. The entry indicated the resident PT/INR results were 46.7/3.9 and another PT/INR was to obtained on 6/30/16. The next entry was completed on 7/13/16. This entry indicated no Anti-Coagulant does was noted. When interviewed on 7/26/16 at 4:15 p.m., the facility administrator indicated a medication error occurred related to Resident #C not receiving any Coumadin between 6/30/16 and 7/12/16. The facility Administrator indicated the Nursing staff should have followed up with the Physician for Coumadin orders.2. During an interview on 07/26/16 at 9:05 a.m., Resident #E indicated she was supposed to receive her medications before she ate breakfast. During an observation, on 07/26/16 at 9:30 a.m., LPN #1 prepared Resident #E's morning medication, which included pantoprazole (Protonix) (ulcer medication) 40 mg (milligrams) and clopidogrel (anti-platelet) 75 mg. LPN #1 administered the morning medications to the resident. Resident #E's record was reviewed on 07/26/16 at 10 a.m. The resident's diagnoses included, but were not limited			

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	07/28/2016

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
	to gastrointestinal bleeding and gastric ulcer. The resident's Hospital History and Physical, dated 07/15/16, indicated the resident had hemorrhage (bleeding) of the gastrointestinal tract. A Complete Blood Count, dated 07/25/16, indicated the red blood cells were 2.82 (normal 4.8-10.8), hemoglobin 8.1 (normal 12.0-16.0) and hematocrit was 25.5 (normal 37.0-47.0). A Physician's Order, dated 07/25/16, indicated to increase the Protonix 40 mg from daily to twice a day at breakfast and dinner. A Physician's Order, dated 07/25/16, indicated to discontinue the clopidogrel. The Medication Administration Record, dated 07/2016, indicated the clopidogrel 75 mg had been discontinued and the Protonix had been increased to twice a day, scheduled for 7 a.m. and 4 p.m. During an interview on 07/26/16 at 11:40 a.m., the B-Unit Manager indicated the clopidogrel had been discontinued. A facility policy, dated 06/2015, titled, "Medication Administration-General			

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	07/28/2016

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
	Guidelines", received from the Administrator as current, indicated, "...FIVE RIGHTS - Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 rights is recommended..." This Federal Tag relates to Complaint IN00205181. 3.1-48(c)(2)			
F 0353 SS=E Bldg. 00	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following			

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	07/28/2016

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
	types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review, and interview, the facility failed to ensure sufficient Nursing Staff were provided to meet the residents needs for medication administration for 1 of 3 Units (B-Unit), which had the potential to effect 38 of 51 residents on 2 of 3 hallways (B and C Hall) (Residents #E, #J, #Q, #R, #T, and #U). Finding includes: During an interview on 07/26/16 at 9:05 a.m., Resident #E indicated she was supposed to receive her medications before she ate breakfast. She indicated she rarely received her medications before breakfast and, "I keep pushing until I get them." During an observation on 07/26/16 at 9:30 a.m., LPN #1 administered the resident's 7 a.m. medication.	F 0353	It is the intent of this facility to ensure that staffing patterns reflect the resident needs. 353 Itis the intent of this facility to ensure that staffing patterns reflect theresident needs. DONreviewed staffing patterns for unit B and adjusted as needed on 7.26.16 for residentsE,J,Q,R,T,U EDreviewed all other Units to ensure optimal staffing was in place on 7.26.16 Educationwas provided to DON in regards to F tag 353 on 8.11.16 by the ExecutiveDirector ED/Designeeto review staffing patterns for optimal compliance by incorporating QIS auditsthat include the resident staffing satisfaction question. 5 resident audits tobe conducted randomly and on all shifts 5 X per week X 1 month, then 5 X permonth x 3 months and then quarterly until 95% compliance is achieved. Anynegative findings will be reviewed in the monthly QUAPI meeting. Dateof compliance 8.25.16	08/25/2016

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	07/28/2016

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
	During an observation on 07/26/16 at 10:15 a.m., Resident #J was propelling her wheelchair down the hallway and asked the B-Unit Manager where her medications were. Resident # J stated, "where's my medicine", "they are real late", "I need my shot of Novolog". During an interview on 07/26/16 at 10:15 a.m., the B-Unit Manager indicated she was not supposed to be on a Medication Cart. She indicated the Nurse for the hallway was on another hall and was passing medication. She indicated the Nurses on the Unit were behind in their medication administration. During an interview on 07/26/16 at 10:25 a.m., the B-Unit Manager indicated the Nurse assigned to the hall was an Agency Nurse and the other Nurse on the Unit was from another corporate facility. During an interview on 07/26/16 at 10:25 a.m., Resident #J indicated no one on the C-Hall had received their medications and indicated this occurs frequently. Resident #J indicated no one checks her blood sugar before she eats, so she has to check her own because when they wait until after she eats, her blood sugar is too high and then she received more insulin. The B-Unit Manager then gave Resident			

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	07/28/2016

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
	#J her morning medications. During an interview on 07/26/16 at 10:35 a.m., LPN #1 indicated she had just finished the morning medication administration on the A-Hall and was now starting the B-Hall. During an interview on 07/26/16 at 10:36 a.m., Resident #Q indicated he had not received his morning medications yet, and the staff were late with medications often. He stated, "it p***** me off." During interviews on 07/26/16 at 10:38 a.m., Residents #R, #T, and #U indicated they had not received their morning medications and indicated this happened frequently. During an interview on 07/26/16 at 10:40 a.m., RN #1 indicated she had not started the morning medications on the C-Hall. During an interview on 07/26/16 at 11:40 a.m., the B-Unit Manager indicated she had just administered Resident #Q's morning medications. The minutes from the 7/7/16 Resident Council meeting indicated (9) residents attended the meeting. Five of the residents voiced concerns related to their pills being passed past the one hour			

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	07/28/2016

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
	window and medications not being correct. During an interview on 07/26/16 at 2 p.m., the Administrator indicated there were usually two full time Nurses' on the B-Unit. This Federal Tag relates to Complaints IN00205091 and IN00205181. 3.1-17(a)			
F 0514 SS=E Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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			

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	07/28/2016

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
	organized. 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. Based on record review and interview, the facility failed to ensure Residents' Records were accurately documented, related to ensuring a Nurse who had administered insulin doses was signing the insulin administration with the correct initials, for 4 of 6 residents' Medication Administration Records reviewed in a sample of 21. (Residents #V, #W, #X, and #Y) Finding includes: During an interview on 07/26/16 at 10:50 a.m., LPN #1 indicated the Night Shift Nurse had obtained the resident's blood sugars and administered the morning insulin doses to the residents. Residents #V, #W, #X, and #Y's Medication Administration Records (MARs), dated 07/2016, were reviewed on 07/26/16 at 2:30 p.m. Residents #V, #W, #X, and #Y's 7 a.m. blood sugars and insulin were signed as given by LPN #1.	F 0514	It is the intent of this facility to ensure that medications are given per the physician order. 514 Itis the intent of this facility to ensure that medications are given per thephysician order. DONreviewed V,W,X and Y's blood sugars and insulin to ensure that no medicationdosage error had occurred. Allother residents who receive insulin were reviewed prior to date of compliance,by the DON/Designee, to ensure appropriate dosage and times were being followedper physician order. DON/Designeeeducated licensed staff in regards to medication passes prior to date ofcompliance. DON/Designeewill audit 5 resident medication passes per week X 1 month then 5 residents permonth X 3 months and then quarterly until 95% compliance is achieved.Medication pass audits will occur randomly on all shifts and includeappropriate documentation of administration. All negative findings willbe reviewed in monthly QUAPI	08/25/2016

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	07/28/2016

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
	During an interview on 07/26/16 at 2 p.m., the Administrator indicated the Night Shift Nurses had given the morning insulin doses. She indicated they had signed the insulins out using LPN #1's initials. The Administrator indicated the Night Shift Nurses had not realized LPN #1 had signed into the computer. During an interview on 07/26/16 at 2:30 p.m., the Director of Nursing (DON) indicated the Night Nurse had not realized she had been logged out of the computer and was signing the insulin being administered under LPN #1's name. During an interview on 07/26/16 at 4 p.m., LPN #2 indicated she had administered the insulin doses to help out the Day Shift. She indicated she had documented the administration in the computer and had thought she was still signed in to the computer. A facility policy, titled, "PCC (Point Click Care) Guidelines", received from the Administrator on 07/27/16 at 12:09 p.m., indicated, "...All users must log into Point Click care using their own user ID and password. It is never appropriate to use Point Click Care when someone is logged in..."		meeting. Dateof compliance 8.25.16	

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	07/28/2016

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
	This Federal Tag relates to Complaint IN00205181. 3.1-50(a)(2)			