STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155375	A. BUILDING 00 B. WING	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-PETERSBURG	309 W PIKE AVE PETERSBURG, IN 47567

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 13, 14, 15, 16, & 17, 2021 Facility number: 000033 Provider number: 155375 AIM number: 100266280 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicare: 2 Medicaid: 26 Other: 9 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 23, 2021.	F 0000	Attached are Plan or Corrections for alleged deficiencies during facility annual survey. Facility is requesting a paper compliance on these deficiencies.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or			

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	on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to provide required notices to residents being discharged from Medicare services for 1 of 3 residents reviewed. The SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notification) was not provided to a resident who remained in the facility. (Resident 21) Findings include: On at 9/16/21 at 10:00 A.M., Resident 21's discharge from Medicare services was reviewed. Resident 21 was discharge from Medicare services on 8/24/21 and remained in the facility. A copy of the SNF-ABN was not provided by the facility. On 9/16/21 at 10:53 A.M., the BOM 10 (Business Office Manager) indicated a Notice of Medicare Non-Coverage was provided to Resident 21, but that they were not familiar with the SNF-ABN form and could not provide a copy that was issued to Resident 21. On 9/16/21 at 2:45 P.M., the Facility Administrator indicated no policy was available regarding issuing the SNF-ABN forms. 3.1-4(f)(2)	F 0582	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents have the potential to be affected by the deficient practice. Facility provided required notices to resident #21. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. The facility will provide the required notices to resident being discharged from Medicare services to residents who remain in facility. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Social Service or designee will be on completion of the SNF-ABN when skilled services are ending for residents who have days remaining.	10/25/2021

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			How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Executive Director or designee will discuss during daily Clinical Start- resident receiving a NOMOC that a SNF-ABN is completed at the same time. A copy of both forms will be to the resident and business office. This will be monitored 5Xweekly for 4 weeks, 3Xweekly for 4 weeks then 2Xweekly for 4 months. Results will be reviewed monthly by the QAPI committee to determine the need for further auditing. Completion date: 10/25/2021	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments			

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	under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure insulin pens were labeled with the prescribing information and the opening date documented on the pen for 3 of 3 medication carts reviewed for medication storage, to ensure expired and/or discontinued medications were properly disposed of, and to ensure scheduled narcotic medications were properly locked for 1 of 2 medication storage rooms observed. (East Unit Medication Storage Room, East and West Unit Medication Carts, Resident 21, Resident 93, Resident 90, Resident 91, Resident 31, Resident 92, Resident 89, Resident 88, Resident 15, Resident 2, Resident 26, Resident 32, Resident 4, Resident 86) Findings include: 1. During an observation of the Center Hall medication cart on 9/16/21 at 2:30 P.M., a Lantus insulin pen, which LPN 6 indicated belonged to Resident 26, did not have the date the pen was first used documented on the pen. 2. During an observation of the North Hall medication cart on 9/16/21 at 2:48 P.M., A Lantus insulin pen, which LPN 6 indicated belonged to	F 0761	What corrective action will be accomplished for those residents found to have been affected by the deficient practice; An audit was completed to identify all residents that use an insulin pen to assure they are all labeled and dated appropriately. All narcotic refrigerators have been audited to assure that no food is stored in the refrigerator and that the lock is intact. All medication and treatment carts have been audited to assure they have no loose debris and/or pills and are clean. All medication rooms have been audited to assure there are no medications that have been discontinued and/or no medications stored for residents who have been discharged. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	10/25/2021

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	Resident 32, did not have the date the pen was first used documented on the pen. 3. During an observation of the North Hall medication cart on 9/16/21 at 2:48 P.M., small pieces of paper and powdered debris were observed in the medication drawer bottoms, and one loose pill was observed in the medication cart drawer bottom. 4. During an observation of the Hall medication cart on 9/16/21 at 2:48 P.M., a Novolog insulin pen, which LPN 5 indicated belonged to Resident 4, did not have the date the pen was first used documented on the pen and the prescribing information was not on the pen. 5. During an observation of the Hall medication cart on 9/16/21 at 2:48 P.M., a Humalog insulin pen, which LPN 5 indicated belonged to Resident 86, did not have the date the pen was first used documented on the pen. During an interview on 9/16/21 at 2:48 P.M., LPN 6 indicated insulin pens were supposed to have the open date documented and the prescribing information on the insulin pen. On 9/16/21 at 1:00 P.M., the Facility Administrator supplied a policy titled, "Insulin Pen" and was dated, 2021. The policy included, "...2. Insulin pens must be clearly labeled with the resident's name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date. 3. If the label is missing, the pen will not be used; a new pen must be ordered from the pharmacy. ...9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation..."6. During an observation on 9/13/21 at 9:35 A.M., several		actions will be taken: All residents who receive insulin ends will be labeled and dated when opened. Medication carts will be cleaned on a routine cleaning schedule. The refrigerator containing narcotics will be locked at all times and monitored for related items. Medication destruction will be completed within 7 days of discontinuation or discharge. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Licensed nurses/QMAs will be educated on labeling and dating medications including insulin pens, storage of medications to include clean cart with no loose debris/pills, narcotic storage and medication disposal/destruction. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: NS or designee will audit insulin pen/labeling and dating, narcotic medication storage to include no food in refrigerator with medication and lock is in place and will audit 1 randomly chosen medication and treatment carts to assure they	

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	medications were observed in the East Hall Medication Storage Room counter with the following resident's names on them: Resident 21, Resident 93, Resident 90, Resident 91, Resident 31, Resident 92, Resident 89, Resident 88. At that time, the Regional Director of Nursing (RDON) indicated some of the residents remained in the facility and some of the residents had discharged from the facility. The RDON indicated that the night shift are responsible for filling out the return form and destroying the medications. An unlocked refrigerator in the Storage Room was observed with the following controlled substances: Morphine (pain medication) belonging to Resident 15, and lorazepam (antianxiety medication) belonging to Resident 2. The refrigerator was also observed with an open bottle of applesauce, a container of chocolate syrup, and an unopened container of yogurt. The RDON indicated that the refrigerator with the narcotics should have been locked, and no food items should have been in the medication refrigerator. The RDON indicated they would fill out the destruction logs at that time, and provide a copy of them. On 9/14/21 at 10:04 A.M., the following Drug Destruction Sheets were provided and reviewed with the RDON: 1. Resident 88: Pantoprazole 40mg quantity 78 discontinued on 8/29/21. 2. Resident 89: Potassium Chloride 20meq quantity 76, and Ipratropium-Albuterol quantity 7. Resident discharged 7/9/21. 3. Resident 31: memantine 10mg quantity 2, donezezil 10mg quantity 2, vitamin D3 quantity 1, and arthritis pain 80mg quantity 2. RDON		are clean and free of debris/loose pills and medication disposal/destruction 5xwkly for 4 weeks, 3xwkly for 4 weeks, 2xwkly for 4 months. Results will be reviewed monthly by the QAPI committee to determine the need for further auditing.	

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indicated all of these medications were refused on 9/2/21, 9/5/21, 9/12/21, 9/14/21, and 9/15/21, and she was unsure from which dates the medications were placed in the Storage Room.

4. Resident 92: Polyethylene glycol 3350 83oz, Novolog flex pen 15cc, Lantus Solostar 10cc, and Ipratropium-Albuterol quantity 100. Resident discharged 8/26/21.

5. Resident 91: Siltussin DM 473ml. Resident discharged 6/4/21.

6. Resident 90: Vitamin E 400units quantity 30, "Peg 3350" 2oz, mirtazapine 7.5mg quantity 4, promethazine 25mg quantity 26, "Acet Supp 650" quantity 12, and Hyoscamine 125mg quantity 52. Resident passed away 8/30/21.

7. Resident 21: melatonin 3mg quantity 1. Resident refused medication on 8/23/21.

8. Resident 93: SMZ/TMP [Bactrim] 800/160 quantity 7, discontinued 8/26/21.

On 9/14/21 at 11:26 A.M., a current Disposal of Medications and Medication-Related Supplies Medication Destruction policy, dated 12/17, was provided, and indicated "All discontinued medications will be immediately removed from the resident's active medication and stored in a separate locked area for up to 90 days or as required by applicable law, and then destroyed by a manner in accordance with applicable state and federal laws."

3.1-25(k)
3.1-25(o)
3.1-25(r)

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to ensure food was stored or prepared in a sanitary manner in accordance with professional standards for food service safety in 2 of 2 observations of the kitchen. Food in the freezer was open to air, food items were open and not dated, and staff observed not properly washing hands during food preparation. (Main Kitchen) Findings include: 1. During an observation on 9/13/21 at 10:08 A.M., the following food items were observed in the kitchen:	F 0812	hat corrective action will be accomplished for those residents found to have been affected by the deficient practice: All food storage areas were audited for opened undated food. Any found to be opened/undated were disposed of. How other residents having the potential to be affected by the same deficient practice will be	10/25/2021

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	A biscuit and gravy mix open and undated A container of cheese balls open and undated Italian seasoning open and undated Chili powder open and undated Pumpkin spice open and undated Ground cinnamon open and undated Garlic salt open and undated Roasted garlic bread seasoning open and undated A bottle of worcestershire sauce open and undated A bottle of catalina dressing open and undated A bottle of salsa open and undated A cardboard box with hamburger patties in the freezer was open to air A plastic container with potato chips was on the counter undated and unlabeled 2. During an observation on 9/16/21 at 10:30 A.M., the following was observed during lunch preparation: While preparing the puree trays, Cook 1 was observed to wash their hands for 7 seconds. While preparing hall trays, Cook 9 was observed to wash their hands for 4 seconds. On 9/16/21 at 1:45 P.M., the RDON (Regional Director of Nursing) indicated there was no specific written policy for open containers in the freezer, however, per the corporate office representative, all items in the freezer should have been closed, either in a box or a bag. On 9/16/21 at 1:00 P.M., an undated facility policy titled, Date Marking for Food Safety policy was provided. The policy included, "The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared." On 9/16/21 at 1:00 P.M., an undated policy titled,		identified and what corrective actions will be taken: Dietary staff will be educated that the individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Dietary staff will be re-educated on food storage/label and dating policy as well as the handwashing policy. How will the corrective action be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Dietary manager or designee will audit food items for proper dating when opened/prepared and proper handwashing by employees 5xwkly for 4 weeks, 3xwkly for 4 weeks, 2xwkly for 4 months. Results will be reviewed monthly by the QAPI committee to determine the need for further auditin	

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	Handwashing Guidelines for Dietary Employees was provided. The policy included, "Rub [hands] together vigorously for at least 20 seconds." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other			

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record	F 0880	What corrective action will be	10/25/2021

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	review, the facility failed to ensure an insulin pen was properly cleaned for 1 of 1 insulin administrations observed, staff did not change their gloves appropriately during care, and did not wash their hands with soap for 20 seconds during 3 of 4 observations of care. (Resident 4, Resident 6, Resident 3, Resident 28) Findings include: 1. During an observation of medication administration on 9/16/21 at 11:35 A.M., LPN 5 removed an insulin pen from the North Hall medication cart. Resident 4's name was written in black marker on the barrel of a Novolog Flex Pen. LPN 5 indicated she did not know what had happened to the plastic bag that contained the prescription details. Without cleaning the tip of the Novolog flex pen with alcohol, LPN 5 primed the Novolog pen tip and attached the disposable needle. LPN 5 was made aware the tip of the insulin pen had not been cleaned and LPN 5 indicated being unaware it was supposed to be cleaned with alcohol. During an interview on 9/16/21 at 2:45 P.M., the Regional Director of Nursing (RDON) indicated the tip of an Insulin pen was supposed to be cleaned with alcohol before attaching the disposable needle every time an insulin pen was used. The RDON also indicated all insulin pens were supposed to be stored in the bag with the prescription label and the pen was supposed to have the date of first use documented on it. On 9/16/21 at 1:00 P.M., the Facility Administrator supplied a policy titled, Insulin Pen and dated, 2021. The policy included, "...g. Attach pen needle: ...Wipe the rubber seal with the alcohol pad... screw the pen needle on to the insulin		accomplished for those residents found to have been affected by the deficient Nurses were immediately educated on cleaning of insulin pen. Unable to immediately correct the alleged deficiency for residents identified improper glove use and handwashing. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. Facility will provide education to nurses in cleaning of insulin pens and nursing assistants education on proper glove use and handwashing. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Nurses will be educated in proper cleansing of the rubber seal with an alcohol prep pad prior to applying the administration needed. Certified Nursing Assistants will be educated proper glove use and handwashing. How the corrective action will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place: DNS or designee will audit cleaning of insulin pens, proper glove use, and handwashing daily on various shifts for 6 weeks, then	

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	155375	A. BUILDING 00 B. WING	09/17/2021

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	pen..." 2. During an observation on 9/14/21 at 10:10 A.M., CNA 2 donned gloves and moistened wash cloths. CNA 2 removed the bed pan, which contained bowel movement, from underneath Resident 28. CNA 2 cleaned Resident 28's peri area, rolled Resident 28 onto their right side, and then rolled and removed the soiled incontinence brief from beneath the resident. After cleaning Resident 28's buttocks, and without changing her gloves, CNA 2 placed a clean depends beneath Resident 28's buttocks, rolled Resident 28 onto their back and secured the depends. CNA 2 took the bed pan to the bathroom where CNA 2 cleaned the pan, removed her gloves, and washed hands for 14 seconds under running water. 3. During an observation on 9/16/21 at 8:25 A.M., CNA 2 was observed wearing gloves when they removed Resident 6's depends and washed their peri area. CNA 2 rolled Resident 6 onto their right side and cleaned bowel movement from between Resident 6's buttocks. CNA 2 rinsed Resident 6's buttocks and then rolled and removed the dirty depends from beneath the resident. Without changing gloves, CNA 2 placed a clean depends beneath the resident and secured the depends tape. CNA 2 then put Resident 6's shirt and pants on and pulled the bed covers up over the resident. CNA 2 gathered the wash pan and took it into the bathroom where they washed it out. CNA removed gloves and washed hands under the water for 10 seconds. 4. During an observation 9/16/21 at 9:40 A.M., CNA 3 was observed to provide hygiene and incontinence care for Resident 3. CNA 3 entered the Resident's room, put on a pair of gloves, and assisted Resident 3 to brush teeth in bed. When completed, CNA 3 removed gloves and ran hands under water for 8		3xwkly for 4 weeks, 2Xwkly for 4 months. Results will be reviewed monthly by the QAPI committee to determine the need for further auditing.	

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	seconds without lathering with soap. CNA 3 then put on another pair of gloves, touched the incontinence pad under the residents, and indicated it was wet. CNA 3 then took gloves off and exited the room. Upon returning, CNA 3 was holding a sheet, 2 incontinence pads, and several wash rags against their uniform top. CNA 3 then placed the clean linen on the bedside table, put on another pair of gloves, filled a basin with water and soap, and placed the wash rags in the basin. The basin was then placed on the floor by the resident's bed, CNA 3 rolled all soiled linen halfway under the resident, wiped the soiled mattress, then cleaned their buttocks with the wash rags from the basin. CNA 3 then applied the clean linen to the mattress, tucking the clean linen against the wet soiled linen that was under the resident. CNA 3 then assisted the resident to roll to the other side and removed all of the dirty linen from the bed. That side of the mattress was not cleaned, and visibly wet. The rest of the bed was made, gloves were removed, and hands washed. During care, CNA 3 pushed their goggles on top of their head twice, and did not change her gloves. Following care, CNA 3 indicated hands should be washed with soap and water for 20-30 seconds, and gloves should be changed in between tasks. On 9/16/21 at 1:00 P.M., an undated facility policy titled, Personal Protective Equipment was provided. The policy included, "Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn." On 9/16/21 at 1:00 P.M., an undated facility policy titled, Hand Hygiene was provided. The policy included, "Apply to hands the amount of soap			

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	recommended by the manufacturer. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse hands with water." 3.1-18(b) 3.1-18(l)			