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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00179466, IN00180680, and IN00180886. Complaint IN00179466- Substantiated. Federal/State deficiencies related to the allegations are cited at F282. Complaint IN00180680-Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Complaint IN 00180886-Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Unrelated deficiency was cited. Survey dates: August 25, 26, and 27, 2015 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census bed type: SNF/NF: 148 Total: 148 Census Payor type: Medicare: 21	F 0000	Submission of this Response and Plan of Corrections is nota legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and Federal law that mandate submission of a plan of correction with ten (10) days of the survey as a condition of participation in the Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. This facility is asking for a desk review for this survey.	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Medicaid: 113 Other: 14 Total: 148 Sample: 11 Quality review completed by 26143, on September 3, 2015. These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.			
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 observation, record review, and interview, the facility failed to ensure Physicians' orders and resident care plans were followed, related to medications and treatments, for 2 of 3 residents reviewed for medications and treatments in a total	F 0282	It is the intent of this facility to ensure that Physician's orders and resident care plans are followed related to medications and treatments. **What corrective action(s) will be**	09/16/2015

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sample of 11. (Residents #B and #D) Findings include: 1. Resident #B's record was reviewed on 08/26/15 at 11:06 a.m. The resident's diagnoses included, but were not limited to stroke, hypertension, and diabetes mellitus. Discharge Orders from the hospital, dated 07/25/15, indicated, "...All of the medications you were taking before and after your hospitalization have been reviewed by your health care provider. After this list review, your health care provider has determined that the list below contains the medications and doses you should be taking. This medication list is the result of the electronically signed discharge medication reconciliation performed by your health care provider." The discharge orders included the following medication orders: amitriptyline (anti-depressant) 25 mg (milligram) 0.5 tablet once daily (12.5 mg) at bedtime Clonidine (anti-hypertensive) 0.3 mg per 24 hour patch, one patch weekly on Thursday. sertraline (anti-depressant) 50 mg, 0.5 tab (25 mg) daily		**accomplished for those residents found to have been affected by the alleged deficient practice:** Resident B deficiencies were identified and corrected. Resident D deficient practice was identified and corrected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents being re-admitted to the facility and residents requiring g-tube care have the potential to be affected by the alleged deficient practices. An audit of residents admitted /re-admitted since 8/27/15 was conducted for accuracy of physician orders and plan of care. An audit of residents with G-tubes was conducted to ensure following orders for care of G-tube dressings and plan of care was reviewed/revised. Any deficient practices with medication and G-tube treatments identified were corrected by contacting Physician for order clarification and updating of plan of care as appropriate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed nurses were re-educated on guidelines for verification of Physician orders and plan of care upon admission/readmission. New admissions/re-admission audits of Physician orders and plans of care	

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	metoclopramide (stomach medication) 10 mg, 0.5 tab (5 mg) four times daily The transfer papers from the hospital, indicated the resident's Clonidine patch had been applied on 07/23/15 at 9 a.m. A Nurses' Note, dated 07/25/15 at 10:43 p.m., indicated the resident was re-admitted to the facility, the Physician had been notified of the resident's return, and the discharge orders were noted. The re-admission Physician's Orders, dated 07/26/15, were re-written by the Nurse as followed: amitriptyline 25 mg give 17.5 mg (sic) (should have been 12.5) at bedtime for depression. give half tab=17.5 (sic) (12.5 mg) The Clonidine Patch had been omitted dipyridamole 25 mg three times a day sertraline tablet 50 mg one time daily metoclopramide 10 mg/ml (milliliters), give 10 ml (10 mg) four times daily The Physician's Order for amitriptyline was re-written by LPN #1 on 07/26/25, with the order to give 25 mg daily at bedtime. The MAR (Medication Administration Record), dated 07/15, indicated the resident received the following		will be conducted by nursing and reviewed by the DNS/designee 3 x weekly for 4 week, 2 x weekly for 8 weeks, and then weekly for 12 weeks. G-tube dressing audits will be done by visual verification by the DNS/designee 3 x weekly for 4 week, 2 x weekly for 8 weeks, and then weekly for 12 weeks. All new Physician orders are reviewed in Start Up meeting for all residents and plan of care is revised as necessary. Total plan of care reviews follows the MDS schedule. This process is on going. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Audit results of admissions/readmissions and G-tube care orders and plan of care will be reported in the QAPI meeting monthly for 6 months or as determined by the QAPI committee. **Date systemic changes will be completed:** 9/16/15	

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications: amitriptyline 25 mg, 1/2 tablet on 07/26/15 at 7 p.m. amitriptyline 25 mg at 7 p.m. on July 27-31, 2015 sertraline tablet 50 mg at 8 a.m. on July 26-31, 2015 metoclopramide 10 mg at 6 a.m., 1 p.m., 6 p.m., and 9 p.m. on July 27-31, 2015 The Clonidine Patch had not been administered as ordered (was due to be applied on 07/30/15) The MAR, dated 08/15, indicated the resident received the following medications: amitriptyline 25 mg at 7 p.m. August 1-5, 2015. The medication was discontinued on 08/06/15. Clonidine Patch 0.3 mg/24 hours was applied on 08/06/15. sertraline 50 mg one time daily at 8 a.m. on August 1-6, 2015 and the time was changed to 9 p.m. on August 7-24, 2015. metoclopramide 10 mg, four times a day August 1-6, 2015, and was then changed to three times a day on August 6, 2015 During an interview with the LPN #2 (C-Unit Manager) and the Executive Director present on 08/27/15 at 1:11 p.m., LPN #2 indicated the amitriptyline 17.5 was an error in transcription and it should have been 12.5 mg. She 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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the change of orders on August 6, 2015 were time changes due to Resident #B's family request. She indicated she was not sure why the amitriptyline dosage had been increased and indicated LPN #1 had increased the dosage. She indicated the other orders written incorrectly were written by LPN #3 and was unsure where LPN #3 had received the changed orders from the hospital discharged orders. LPN #2 indicated the Nurses' were to document the reason for the change in orders and if the Physician had changed the hospital discharge orders. During the interview with LPN #2, the Corporate Consultant entered the room and indicated LPN #3 had resigned from the facility on 07/26/15. LPN #2 further indicated the Clonidine Patch had not been re-started as ordered. LPN #2 indicated she was "sure I caught it" (Clonidine Patch) on August 6, 2015, and just didn't document the error. She indicated the resident went 14 days without the Clonidine patch being changed. LPN #2 indicated "I'm sure I looked to see if other orders were correct." During an interview on 08/27/15 at 2:03 p.m. with LPN #1 and the Executive Director present, LPN #1 indicated she had not been in the facility when the resident was re-admitted into the facility.			

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She indicated the resident arrived later in the evening. She indicated she had worked the C-Unit on July 26, 2015 and had seen the re-admission of the resident had not been completed correctly. She indicated she had looked at the admission papers and say some of the medications were discontinued and some medications were added. She indicated LPN #3 had not updated the medications and she did not know if the Physician had been notified of the orders by LPN #3. LPN #3 further indicated she had changed the amitriptyline order to 25 mg because this was the dosage she thought was ordered. She indicated she had not called to clarify the order with the Physician. She indicated the written order for the amitriptyline was deceptive and she did not think the order was for a half tablet of 25 mg. During an interview with Director of Nursing (DoN) on 08/27/15 at 3:11 p.m., she indicated LPN #2 was the Admission Nurse and at this time was also the C-Unit, Unit Manager. She indicated as the Admission Nurse, she was to look at all new admission to ensure the admission and orders were correct. She indicated the Admission Nurse had not went over the return admission until a later time.			

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Hospital Discharge Orders for Resident #B, dated 07/25/15, also included dipyridamole (dilates blood vessels) 25 mg three times a day. The MAR, dated 07/15, indicated the resident had received the dipyridamole 25 mg at 8 a.m., 12 p.m., and 4 p.m. on July 26-30, 2015. The MAR indicated on 07/31/15 the dipyridamole 25 mg was held at 8 a.m. and was unavailable at 12 p.m. A Nurses' Note, dated 07/31/15 at 12:30 p.m., indicated the dipyridamole 25 mg was unavailable in the medication cart and the emergency drug kit and was needed to be sent to the facility from the local back up pharmacy. A Nurses' Note, dated 07/31/15 at 3:32 p.m., indicated the Physician had been informed the dipyridamole 25 mg had not been available and a new order was received to discontinue the 25 mg and start dipyridamole 75 mg daily. A Packing Slip, dated 07/31/15, indicated 42 dipyridamole 25 mg tablets had been delivered to the facility. During an interview on 08/27/15 at 3:40 p.m., LPN #2 indicated she was unsure			

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	what dose of dipyridamole had been given or if any had been given July 26-30, 2015 since the Pharmacy had not delivered the dipyridamole 25 mg until 07/31/15. A Physician's Order, dated 07/31/15 at 3:15 p.m., indicated an order for dipyridamole tablet 75 mg every morning. A Physician's Order, dated 07/31/15 at 3:17 p.m., indicated an order to discontinue dipyridamole tablet 25 mg three times a day. The MAR, dated 08/15, indicated the resident received dipyridamole 75 mg daily on August 1-3, 2015. The MAR, dated 08/15, indicated the dipyridamole 75 mg daily had been discontinued on 08/03/15 and dipyridamole 25 mg three times a day was administered on August 4-6, 2015. The MAR, dated 08/15, indicated the dipyridamole 25 mg three times a day had been discontinued on 08/06/15 and dipyridamole 75 mg daily was administered on August 7-25, 2015. There were no orders in the resident's record to indicate the Physician had			

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	changed the dipyridamole orders on 08/03/15 and 08/06/15. During an interview on 08/27/15 at 1:11 p.m. with LPN #2 and the Executive Director present, LPN #2 indicated she was not positive what occurred with the dipyridamole orders and she had notified the Physician for clarification and the Physician had ordered dipyridamole 75 mg daily. 2. During an observation on 08/25/15 at 9:53 a.m. Resident #D was lying in bed. The resident's family member was at the bedside. The resident had no dressing around the feeding tube site on the abdomen. During an observation on 08/25/15 at 3:55 p.m., Resident #D was lying in bed. The resident had no dressing around the feeding tube site on the abdomen. LPN #2, who was present during the observation, indicated there was no Aquacel dressing around the resident's feeding tube site. Resident #D's record was reviewed on 08/25/15 at 2:47 p.m. The resident's diagnoses included, but were not limited to stroke and convulsions. A Physician's Order, dated 08/04/15,			

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated to continue the Aquacel dressing around the feeding tube site daily to absorb the gastric contents and to help keep the abdomen dry. The MAR, dated 08/15, indicated the feeding tube site was to be cleansed with normal saline and an Aquacel dressing was to be placed at the feeding tube site every night. The MAR had initials to indicated the Aquacel dressing was in place on 08/24/15 during the night shift and had no initials to indicate the Aquacel dressing was in place during the night shift on 08/25/15. This Federal Tag relates to Complaints IN00179466. 3.1-35(g)(2)			

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident had proper assistance and supervision during a transfer, related to one staff member transferring a resident with a mechanical lift and leaving the resident unattended, which the resident fell from the lift, for 1 of 3 residents reviewed for mechanical lift transfers and falls in a total sample of 11. (Resident #C) Finding Includes: Resident #C's record was reviewed on 08/27/15 at 9:05 a.m. The resident's diagnoses included, but were not limited to dementia and diabetes mellitus. An Annual Minimum Data Set assessment, dated 05/09/15, indicated the resident's cognition was intact, required extensive assistance of two for transfers, and had one fall with injury. A Nurses' Note, dated 07/26/15 at 9:55 a.m., indicated the resident was being transferred with a lift, and the resident	F 0323	It is the intent of this facility to ensure residents have proper assistance and supervision during a transfer. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Event was self identified by the facility prior to survey. Physician and family were notified at the time of event. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents requiring mechanical lift transfers have the potential of being affected by the alleged deficient practice. Nursing staff was re-educated on the practice of mechanical lift transfers. **What measures will be put into place or what systemic changes will be made to ensure that the**	09/16/2015

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had slipped to the floor, hitting her head on the floor and was then transferred to the Emergency Room by the Ambulance. The Emergency Room notes, dated 07/26/15, indicated the resident had a superficial posterior scalp abrasion. The fall investigation, dated 07/26/15, indicated CNA #4 had transported the resident by the sit to stand lift, from the bathroom to the resident's room without help of another staff member. CNA #4 then left the resident standing on the lift and went into the bathroom, leaving the resident unattended, and the resident fell backwards off the sit to stand lift. During an interview on 08/27/15 at 8:56 a.m., the Director of Nursing indicated the facility did not have a policy for the use of the sit to stand lift. She indicated the staff were to use two staff members for all transfers with lifts. She indicated there was nothing in writing and the staff watches a video, which states two people were to be used with lift transfers. A Professional Resource, titled "Indiana State Department of Health Division of Long Term Care Nurse Aide Training Program July 1998", Topic 22:Transferring, indicated, "...Have at least one co-worker assist when using a		**deficient practice does not recur:** New staff are educated on mechanical lift transfers during orientation. Nurse aide care cards were audited to assure residents requiring mechanical lifts are identified. DNS/designee will do spot observations of mechanical lift transfers 3 x weekly for 4 week, 2 x weekly for 8 weeks, and then weekly for 12 weeks. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Results of observations will be reported to the QAPI for 6 months and then as determined by the QAPI committee. **Date systemic changes will be completed:** 9/16/2015	

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mechanical lift..." This Federal Tag relates to Complaints IN00180680 and IN00180886. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to follow standard cleaning precautions during the performance of routine testing of blood glucose levels, related to disinfecting a glucometer (checks blood sugars) after usage, this had the potential to affect 4 residents who reside on the C-Unit, who require blood glucose level testing. (LPN #5) Finding includes: During a medication administration observation on 08/26/15 at 9:25 a.m., LPN #5 entered Resident #B's room and completed a blood sugar test with the glucometer. After completion of the test, LPN #5 placed the glucometer in her uniform pocket and exited the resident's room. During an observation on 08/26/15 at 9:38 a.m., 9:47 a.m., and 9:52 a.m., LPN #5 had not removed the glucometer from	F 0441	It is the intent of this facility to provide a sanitary environment to prevent the spread of infection related to cleaning precautions during the performance of routine testing of blood glucose levels. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Resident B was not affected by the alleged deficient practice. No other residents were affected by the alleged deficient practice. Medical Director was informed of deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents requiring glucometer testing have the potential to be affected by this alleged deficient practice. Licensed nurses were	09/16/2015

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her pocket. During an interview on 08/26/15 at 9:53 a.m., LPN #5 indicated she had not disinfected the glucometer. LPN #5 indicated the glucometer was in her pocket. LPN #5 then removed the glucometer from her pocket and placed the glucometer in the Medication Cart drawer. LPN #5 indicated she still had not disinfected the glucometer. LPN #5 then removed the glucometer from the drawer and used an alcohol prep wipe to wipe off the glucometer. During an interview on 08/26/15 at 12 p.m., the Director of Nursing indicated the policy indicated a bleach wipe was to be used to disinfect the glucometer. A facility policy, dated 12/14, titled, "Blood Sampling-Capillary (Finger Sticks) Level III", received from the Director of Nursing as current, indicated, "...Always ensure that blood glucose meters intended for reuse are cleansed and disinfected between resident uses...Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use..." The Manufacturer's Instructions, received on 08/26/15 at 3 p.m. from the D & E		re-educated on the process of disinfecting the glucometer. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/designee will complete visual checks on all shifts of glucometer disinfecting procedures for 3 x weekly for 4 week, 2 x weekly for 8 weeks, and then weekly for 12 weeks. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Results of checks will be reported to QAPI and will monitor monthly for 6 months and continued as determined by QAPI. **Date systemic changes will be completed:** 9/16/2015	

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	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Unit-Unit Manager, indicated, "...Meter should be cleaned and disinfected between each patient..Hospital Disinfectant Towels with Bleach...Disinfecting, Deodorizing, Cleaning Wipes with Alcohol...Bleach Germicidal and Disinfectant Wipes...Bleach Germicidal Bleach Wipes...to disinfect your meter, clean the meter surface with one of the approved disinfecting wipes..." 3.1-18(a) 3.1-18(j)			