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

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

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F 0000 Bldg. 00	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00179466, IN00180680, and IN00180886 completed on August 27, 2015 which cited an unrelated deficiency. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00176471, IN00177742, IN00177395, and IN00177997 completed on July 16, 2015. This visit was in conjunction with the Investigation of Complaints IN00181613 and IN00181770. Complaint IN00179466- Not corrected Complaint IN00180680- Corrected Complaint IN00180886- Corrected Survey dates: September 29 & 30, 2015 and October 1, 2015. Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census bed type:	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.	

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

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	SNF/NF: 146 Total: 146 Census payor type: Medicare: 26 Medicaid: 108 Other: 12 Total: 146 Sample: 13 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on October 8, 2015.			
F 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 ensure a Resident's Physician's re-admission orders were	F 0282	It is the intent of this facility to provide a sanitary environment to prevent the spread of infection related to cleaning precautions	10/15/2015

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	followed, related to medications, for 1 of 3 residents reviewed for Physician's Re-admission orders in a total sample of 13. (Resident #J) Findings include: Resident #J's record was reviewed on 09/30/15 at 10:12 a.m. The resident's diagnoses included, but were not limited to dementia and diabetes mellitus. A Physician's Order, dated 09/22/15, indicated an order for Depakote Sprinkles (epilepsy medication used for a mood stabilizer) 250 mg (milligrams) one time a day at 8 a.m. and 500 mg at bedtime. A Nurses' Progress Note, dated 09/26/15 at 12:25 p.m., indicated the resident had been transferred to the hospital due to chest pain. A Nurses' Progress Note, dated 09/29/15 at 4 p.m., indicated the resident had returned to the facility. The re-admission Physician's Orders, dated 09/29/15, included Depakote Sprinkles, 125 mg, take 250 mg nightly. The Medication Administration Record, dated 09/15, indicated Depakote Sprinkle 500 mg was administered on 09/29/15 at		during the performance of routine testing of blood glucose levels. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The nurse completing the Accu-check on resident F completed the action. There were no adverse affects for this resident r/t the procedure. The nurse was asked by the surveyor to return to the medication cart before completing an Accu-check for resident S. There were no adverse affects for this resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential of being affected by this alleged deficient practice. The nurse was immediately re-educated on infection control guidelines including hand washing on 9/30/2015 by the Unit manager. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** On 9/30/2015 the Unit managers/Director Nursing Services/Designee immediately started re-education with staff on Infection control/handwashing. Infection control/handwashing guidelines were also included in facility Fireside Chats led by the	

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	7 p.m. and 250 mg of Depakote Sprinkle 250 mg was administered on 09/30/15 at 8 a.m. During an interview on 09/30/15 at 11:19 a.m., the 100 Unit Manager indicated the incorrect dose of Depakote Sprinkle was given at 7 p.m. on 09/29/15 and 8 a.m. on 09/30/15. She indicated a medication error occurred and a Medication Error Report would be initiated. This deficiency was cited on 08/27/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)		Executive Director and the Director Nursing Services on 10/5/2015. The Director Nursing Services/ Designee will observe handwashing demonstrations 5 times per week for 4 weeks on clinical staff then random employee observations will be done monthly by department managers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Trends and patterns of deviation from guidelines of Infection control/hand washing will be reviewed during monthly QAPI monthly for 6 months, then continuing as QAPI team determines necessary. **Date systemic changes will be completed:** 10/15/2015	
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			

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	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 their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure hand hygiene was performed and gloves were worn during the administration of an insulin injection, after the use of the glucometer, and between resident to resident contact for 1 of 2 residents observed for blood glucose monitoring in a sample of 13. (Residents # F and #S) (LPN #2) Finding includes:	F 0441	It is the intent of this facility to provide a sanitary environment to prevent the spread of infection related to cleaning precautions during the performance of routine testing of blood glucose levels. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The nurse completing the Accu-check on resident F completed the	10/15/2015

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

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	wash her hands after she removed her gloves. The LPN then signed out the glucometer test results on the computer attached to the Medication Cart. LPN #2 then removed a vial of insulin and a syringe from the Medication Cart and prepared a dose of insulin for Resident #F. The resident was standing next to the Medication Cart and he picked up his shirt and requested the LPN administer the insulin in his abdomen. LPN #2 injected the insulin into the right side of the resident's abdomen. The LPN did not wear gloves while injecting the insulin. The LPN then placed the insulin vial back into the Medication Cart, removed the disinfectant wipe from the glucometer, and threw the wipe away. The LPN then went into the bathroom in the small Dining Room on the unit and obtained a new pair of disposable gloves and returned to the Medication Cart. The LPN picked up the glucometer and test strips and entered the large Dining Room. LPN #2 then approached Resident #S and informed the resident she was going to test her blood sugar. The LPN put on the new pair of gloves and removed a test strip from the bottle and placed her hand on the resident's hand. The LPN was requested to return to the Medication Cart		4 weeks on clinical staff then random employee observations will be done monthly by department managers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Trends and patterns of deviation from guidelines of Infection control/hand washing will be reviewed during monthly QAPI monthly for 3 months, then quarterly. **Date systemic changes will be completed:** 10/15/2015	

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

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	body fluids. This deficiency was cited on 08/27/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1- 18(l)			