

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint #I IN00182950</p> <p>Complaint # IN00182950 - Substantiated - No deficiencies related to the allegations were cited.</p> <p>Survey dates: October 26, 27, 28, 29, 30, November 2, 4, and 5, 2015.</p> <p>Facility number: 000258 Provider number: 155367 AIM number: 100289160</p> <p>Census bed type: SNF/NF: 92 Total: 92</p> <p>Census payor type: Medicare: 8 Medicaid: 74 Other: 10 Total: 92</p> <p>Sample- 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	Preparationm, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Ou Plan of Correction is prepared and excecuted as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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: 155367		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901			
(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 0309 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality Review was completed by 21662 on November 12, 2015.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interviews, the facility failed to ensure pain was managed, for a resident with known chronic pain for 1 of 3 residents reviewed for pain. (Resident #53)</p> <p>Findings include:</p> <p>The record for Resident #53 was reviewed on 10/29/15 at 9:10 a.m. Diagnoses for Resident #53 included, but were not limited to, hemiplegia and hemiparesis following</p>	F 0309	<p>Audit was completed for resident #53 to ensure that pain medication is currently available. Pain assessment was completed for resident #53 to ensure that current pain medication is effective at managing pain. Audit of all residents with narcotic pain medications was completed to ensure that prescribed pain medication is available. No other residents identified to have been affected by the deficient practice. Licensed nursing staff in-serviced on proper procedure for ensuring availability of pain medication.</p>	12/05/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901			
(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>cerebrovascular disease, congestive heart failure, depression, chronic abdominal pain, and high blood pressure.</p> <p>The September 2015 Physicians Recapitulation indicated a physicians order, dated 12/8/14, for a pain medication, Norco Tablet (hydrocodone-acetaminophen) 10-325 milligrams (mg), give 1 tablet, by mouth, three times a day for general pain.</p> <p>The September 2015 Medication Administration Record (MAR) indicated the Norco, pain medication, was not administered at the following times: 9/26/15 at 9:00 p.m. 9/27/15 at 1:00 p.m. and 9:00 p.m. 9/28/15 at 1:00 p.m.</p> <p>Nursing notes indicated the following: 9/23/15 at 3:08 a.m., "...Has routine Norco for effective pain management." 9/26/15 at 9:20 p.m., [Norco] medication not available, nurse practitioner (NP) aware. 9/27/15 at 12:07 p.m., [Norco] medication unavailable. 9/27/15 at 5:09 p.m., complains of pain to hip 9/27/15 at 9:50 p.m., [Norco] Medication not available from pharmacy, need new script. 9/28/15 at 3:09 p.m., [Norco] drug</p>		<p>Upon receipt of a narcotic pain medication order, the nurse is to ensure proper hard prescription is obtained from the physician. The nurse is to then make a copy of the script and fax the hard script to pharmacy. A confirmation page is received via fax once complete. A copy of the script as well as the confirmation sheet is to be placed in a binder designated for narcotic prescriptions at each nurse's station. UM/DCE/designee to then follow up to ensure that confirmation was received at pharmacy and then log the date and the resident's name in the binder with the anticipated date of depletion. UM/DCE/designee is to review this log book every business day at clinical start up. Prior to the prescription depletion date, the UM/DCE/designee is to notify the physician of the anticipated depletion of the prescribed medication and obtain a new hard prescription. Results of these audits are to be reviewed at QAPI monthly for a minimum of 6 months to track for any trends. If any trends identified, then audits are to be completed on QAPI recommendations. If no trends are identified, then reviews will be completed on PRN basis.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>unavailable</p> <p>A care plan, dated 10/15/14, indicated, "Needs Pain management and monitoring related to: Chronic Pain, joint stiffness...</p> <ul style="list-style-type: none"> · Administer Pain medication as ordered: Norco, Flexeril, Tylenol · Biofreeze to shoulders, knees and hip per orders · Evaluate and Establish level of pain on numeric scale/evaluation tool prn · Evaluate characteristics and frequency/pattern of pain prn · Evaluate need to provide medications prior to treatment or therapy · Utilize pain monitoring tool to evaluate effectiveness of interventions prn." <p>During an interview on 10/29/15 at 11:21 a.m., the Director of Nursing (DON) indicated Resident #53 should not have went without pain medications. The DON indicated she was working on the floor on the evening shift of 9/26/15. At the time for medication administration, she noted Norco was not available for Resident #53 and it was not available via the emergency drug kit (EDK), either. Since Norco was classified as a narcotic, it was unavailable over the weekend. She knew at that time, the Norco would not be available from the pharmacy until later in the day on 9/28/15. The DON</p> 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>indicated she did not believe the Norco was administered on 9/27 & 9/28 at 5:00 a.m., because it was not available, even though documentation on the eMAR indicated it was administered. The DON indicated the facility used an automatic drug dispenser unit [electronic machine]. The automatic drug dispenser unit was programmed to notify the prescribing physician, via fax, when a refill was needed, 7 days prior to running out. The automatic drug dispenser unit was programmed to notify the facility if the physician did not respond to the pharmacy fax. The DON indicated those faxes were not available, the system failed. She indicated other pain management interventions were not offered or attempted. Documentation related to physician notification related to the possibility of use of other pain medication was not noted or presented.</p> <p>Documentation to indicate pain assessments were completed while Resident #53 went without pain medication, was not noted or presented by the time of the survey exit.</p> <p>3.1-37(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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 0329 Bldg. 00	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review the facility failed to follow a physician's order for a laboratory testing for 1 of 5 residents reviewed for unnecessary medication (Resident # 50).</p> <p>Findings include:</p> <p>The record for Resident #50 was reviewed on 10/30/15 at 11:06 a.m. Diagnoses included, but were not limited to, dementia, end stage renal disease, hypertension, anemia, hyperlipidemia,</p>	F 0329	Physician and family notified of lab not being obtained for Resident #50. Valproic acid level was obtained on 10/31/15 and physician reviewed lab. All residents with labs related to medication monitoring were reviewed to ensure labs were drawn. No other residents identified to be affected by the deficient practice. Licensed nursing staff in-serviced on proper procedure for taking a lab order. When nurse receives a new order for a lab, the nurse is to put the order in the computer	12/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>anxiety, and insomnia.</p> <p>Resident #50 had a physician's order dated 6/17/2015 for Divalproex Sodium Capsule Sprinkles 125 milligrams (mg) (a mood stabilizer medication) 1 capsule every day by mouth at bedtime.</p> <p>Resident #50 had a physician's order dated 6/17/2015 for the laboratory (lab) testing for Valproic Acid Level (VPA) every 3 months.</p> <p>Resident #50's laboratory record for 9/17/2015 did not indicate a VPA was completed. No laboratory test results were found.</p> <p>During an interview on 10/30/2015 at 3:30 p.m., with Unit Manager #1, she indicated the lab work was not completed for resident #50.</p> <p>A policy "Clinical Guide: Lab Processing /Tracking" no date, received on 11/2/2015 at 10:22 a.m., from Unit Manager #1 indicated "...To ensure that diagnostic tests are processed, ordered, obtained and performed and that results are received timely... 6. Place the requisition duplicate in the back of the lab manual/book or designated facility location...."</p>		<p>and then fill out a lab requisition. The lab requisition is to then be faxed to Twin Rivers Lab. UM/DCE/designee to review all new lab orders every business day at clinical start up. UM/DCE/designee to place lab order with date lab is to be drawn in lab tracking binder. UM/DCE/designee to audit lab tracking binder to ensure lab was drawn and reported to physician. These audits to be completed every business day x 30 days, then 3 times weekly x 30 days, then 2 times weekly x 30 days, then weekly thereafter to ensure lab was drawn and reported to physician. Results of these audits to be reviewed at QAPI monthly for a minimum of 6 months to track for any trends. If any trends are identified, then audits are to be completed on QAPI recommendations. If no trends are identified, then audits will be completed on PRN basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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 0371 SS=F Bldg. 00	<p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was labeled and dated and expired food was discarded in 1 of 1 kitchens in the facility. This deficient practice had the potential to affect 91 of 91 residents.</p> <p>Findings include:</p> <p>During the kitchen tour on 10/26/2015 at 10:31 a.m., the following observations were made:</p> <p>1.) The refrigerator was observed with the following open and undated items: a. a container of fresh diced potatoes b. a container of fresh diced celery</p>	F 0371	<p>F371 The facility will store, prepare, distribute and serve food under sanitary conditions.</p> <p>1) Expired Carrots were discarded on 10/24/15.</p> <p>2) Open/Undated Food Items were discarded on 10/26/15 including: diced potatoes, diced celery, orange juice, thawing hamburgers, thawing pork.</p> <p>3) Dietary staff were</p>	12/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901		
(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>c. a pitcher of orange juice d. a box of thawing hamburgers e. a package of thawing pork</p> <p>2.) The refrigerator was observed to have an open container of carrots with an expiration date of 10/24/15.</p> <p>During an interview with the Dietary Manager on 10/26/15 at 10:38 a.m., he indicated all items should be labeled with an open date and a use by date and expired items should be discarded.</p> <p>Review of facility policy titled "Storage of Refrigerated Foods" received from the Dietary Manager on 10/30/15 at 10:35 a.m., indicated "...Foods storage Follow these guidelines regarding foods stored in the refrigerator...Label and note pull date with "use by" date on all food items when removing from freezer...All items not stored in original container must be labeled and noted with "use by" date according to storage chart, used or discarded within allowed days..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>educated on food storage procedures including: storage of refrigerated foods, labeling, dating, and use-by-dates on 10-28-15 by the Dining Services Manager and Registered Dietitian.</p> <p>4) Cold food storage procedures; labeling and dating will be monitored by the Dietary Services Manager (or designee with the manager is absent) at least one time per day five days per week for 4 weeks, then 4 times per week for and additional 4 weeks, then three times per week for an additional 4 weeks. A food storage monitoring checklist will be completed during rounds and kept by the Dining Manager with a copy provided to the Executive Director.</p> <p>5) The Dining Services Manager will report any trends of deficiencies found to the QAPI Committee on a monthly basis for at least 3 months and for any recommendations and resolutions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>6) Deficient practice will be completed by: 12-5-15.</p> <p>F371 Monitoring Tool</p> <p>Date: _____</p> <p>DSM to complete at least 5 days a week in addition to normal rounds.</p> <p>Item</p> <p>Compliant (Y or N)</p> <p>If No; Corrective Action</p> <p>ALL items in walk-in refrigerator labeled and dated with Use By Date (UBD)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interviews, the facility failed to ensure pain medication was available for 1 of 11 residents reviewed for pharmacy services. (Resident #53)</p> <p>Findings include:</p> <p>The clinical record for Resident #53 was reviewed on 10/29/15 at 9:10 a.m. Diagnoses for Resident #53 included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular disease, congestive heart failure, depression, chronic abdominal pain, and high blood pressure.</p> <p>The September 2015 Physicians Recapitulation indicated a physicians order, dated 12/8/14, for a pain medication, Norco Tablet (hydrocodone-acetaminophen) 10-325 milligrams (mg), give 1 tablet, by mouth,</p>	F 0425	<p>Audit was completed for resident #53 to ensure that pain medication is currently available. Audit of all residents with narcotic pain medications was completed to ensure that prescribed pain medication is available. No other residents identified to have been affected by the deficient practice. Licensed nursing staff in-serviced on proper procedure for ensuring availability of pain medication. Upon receipt of a narcotic pain medication order, the nurse is to ensure proper hard prescription is obtained from the physician. The nurse is to then make a copy of the script and fax the hard script to pharmacy. A confirmation page is received via fax once complete. A copy of the script as well as the confirmation sheet is to be placed in a binder designated for narcotic prescriptions at each nurse's station. UM/DCE/designee to then follow up to ensure that confirmation was received at pharmacy and then log the date and the resident's name in the</p>	12/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>three times a day for general pain.</p> <p>Nursing notes indicated the following: 9/23/15 at 3:08 a.m., "...Has routine Norco for effective pain management." 9/26/15 at 9:20 p.m., [Norco] medication not available, nurse practitioner (NP) aware. 9/27/15 at 12:07 p.m., [Norco] medication unavailable. 9/27/15 at 5:09 p.m., complains of pain to hip 9/27/15 at 9:50 p.m., [Norco] Medication not available from pharmacy, need new script. 9/28/15 at 3:09 p.m., [Norco] drug unavailable</p> <p>A care plan, dated 10/15/14, indicated, "Needs Pain management and monitoring related to: Chronic Pain, joint stiffness...</p> <ul style="list-style-type: none"> · Administer Pain medication as ordered: Norco, Flexeril, Tylenol · Biofreeze to shoulders, knees and hip per orders · Evaluate and Establish level of pain on numeric scale/evaluation tool prn [as needed] · Evaluate characteristics and frequency/pattern of pain prn · Evaluate need to provide medications prior to treatment or therapy · Utilize pain monitoring tool to evaluate effectiveness of interventions 		<p>binder with the anticipated date of depletion. UM/DCE/designee is to review this log book every business day at clinical start up. Prior to the prescription depletion date, the UM/DCE/designee is to notify the physician of the anticipated depletion of the prescribed medication and obtain a new hard prescription. Results of these audits are to be reviewed at QAPI monthly for a minimum of 6 months to track for any trends. If any trends identified, then audits are to be completed on QAPI recommendations. If no trends are identified, then reviews will be completed on PRN basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>prn"</p> <p>During an interview on 10/29/15 at 11:21 a.m., the Director of Nursing (DON) indicated Resident #53 should not have went without pain medications. The DON indicated she was working on the floor on the evening shift of 9/26/15. At the time for medication administration, she noted Norco was not available for Resident #53 and it was not available via the emergency drug kit (EDK), either. Since Norco was classified as a narcotic, it was unavailable over the weekend. She knew at that time, the Norco would not be available from the pharmacy until later in the day on 9/28/15. The DON indicated she did not believe the Norco was administered on 9/27 & 9/28 at 5:00 a.m., because it was not available, even though documentation on the eMAR indicated it was administered. The DON indicated the facility used an automatic drug dispenser unit [electronic machine]. The automatic drug dispenser unit was programmed to notify the prescribing physician, via fax, when a refill was needed, 7 days prior to running out. The automatic drug dispenser unit was programmed to notify the facility if the physician did not respond to the pharmacy fax. The DON indicated those faxes were not available, the system failed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901		
(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 0428 SS=D Bldg. 00	<p>3.1-25(a)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review the pharmacy failed to identify a physician's laboratory order was followed for 1 of 5 residents reviewed for unnecessary medication (Resident # 50).</p> <p>Findings include:</p> <p>The record for Resident #50 was reviewed on 10/30/15 at 11:06 a.m. Diagnoses included but were not limited to, dementia, end stage renal disease, hypertension, anemia, hyperlipidemia, anxiety, and insomnia.</p> <p>Resident #50 had a physician's order dated 6/17/2015 for Divalproex Sodium Capsule Sprinkles 125 milligrams (mg) (a mood stabilizer medication) 1 capsule</p>	F 0428	Physician and family notified of lab not being obtained for Resident #50. Valproic acid level was obtained on 10/31/15 and physician reviewed lab. All residents with labs related to medication monitoring were reviewed to ensure labs were drawn. No other residents identified to be affected by the deficient practice. Licensed nursing staff in-serviced on proper procedure for taking a lab order. When nurse receives a new order for a lab, the nurse is to put the order in the computer and then fill out a lab requisition. The lab requisition is to then be faxed to Twin Rivers Lab. UM/DCE/designee to review all new lab orders every business day at clinical start up. UM/DCE/designee to place lab order with date lab is to be drawn	12/05/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901		
(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>every day by mouth at bedtime.</p> <p>Resident #50 had a physician's order dated 6/17/2015 for the laboratory testing for Valproic Acid Level (VPA) every 3 months.</p> <p>Resident #50's laboratory record for 9/17/2015 did not indicate a VPA was completed. No laboratory test results were found.</p> <p>Resident #50's pharmacy review for October 2015 failed to report the irregularity of an incomplete laboratory testing for VPA to the Director of Nursing.</p> <p>During an interview on 10/30/2015 at 3:30 p.m., with Unit Manager #1, she indicated the laboratory testing for VPA was not completed for Resident #50.</p> <p>A policy "Consultant Pharmacist Services Provider Requirements" dated 5/2012, received on 11/2/2015 at 10:30 a.m., from the Clinical director of Education indicated " ...2.) Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders as well as recommendations for changes in</p>		<p>in lab tracking binder. UM/DCE/designee to audit lab tracking binder to ensure lab was drawn and reported to physician. These audits to be completed every business day x 30 days, then 3 times weekly x 30 days, then 2 times weekly x 30 days, then weekly thereafter to ensure lab was drawn and reported to physician. During monthly psychotropic review meetings, UM/designee will review labs related to medication monitoring with licensed pharmacist consultant to identify any irregularities. Any irregularities will be reported to the attending physician. Results of these monthly psychotropic meetings and lab tracking audits to be reviewed at QAPI monthly for a minimum of 6 months to track for any trends. If any trends are identified, then audits are to be completed on QAPI recommendations. If no trends are identified, then audits will be completed on PRN basis.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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 0465 SS=E Bldg. 00	<p>medication therapy and monitoring of medication therapy at least monthly...."</p> <p>3.1-25(i)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure dining rooms, hallways (100, 200, and 400), handrails and 14 of 35 resident rooms were clean and in good repair. (Room's # 110, 127, 128, 130, 205, 207, 208, 321, 324, 328, 405, 406, 408, and 411)</p> <p>Findings include:</p> <p>1. During the initial tour on 10/26/2015 at 11:30 a.m., the following was observed:</p> <p>a.) The bedroom doors and entrance arch ways for rooms # 205, 207, and 208 were gouged, chipped and peeling.</p>	F 0465	<p>F 465</p> <p>Completion date: 12/05/2015</p> <p>The following corrective actions will be taken by the facility's maintenance and housekeeping staff:</p> <p>1a. The bedroom doors and entry arch ways for rooms #205, 207, and 208 will be sanded and repainted to eliminate the gouging, chipping, and peeling.</p> <p>1b. The ceiling panels above the housekeeping door and outside room #216 will be replaced with new panels.</p> <p>1c. The dining area across from room #201 will be sanded and</p>	12/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>b.) The ceiling panel above the housekeeping door and the ceiling panel outside room # 216 was loose, separated from the ceiling, chipped and cracked.</p> <p>c.) The dining area across from room #201, had marred chipped, peeling walls and loose and water stained ceiling panels.</p> <p>d.) The hand railing around the dining area across from room #201, were gouged and splintered.</p> <p>e.) The air vent above the 1st floor nursing station, near rooms #215 and 216 was loose, chipped and cracked.</p> <p>f.) The heating floor vent outside room #221 was cracked and loose.</p> <p>g.) The handrails outside of rooms #127 and 129 had exposed nails on handrail.</p> <p>h.) Room #110 had exposed orange colored pipes, located inside the resident room and above the doorway.</p> <p>2. During resident room observations on 10/27/2015, and 10/28/2015, the following was observed:</p> <p>a.) Room #208 on 10/28/2015, at 9:30 a.m., the bathroom wall and door were</p>		<p>repainted in those areas where there is marring, chipping, and peeling walls. Also all loose and water stained ceiling tile will be replaced with new panels.</p> <p>1d. The hand rails around the dining area across from room #201 will be sanded and refinished to eliminate all gouges and splinters.</p> <p>1e. The air vent above the 1st floor nurses station near rooms #215 and 216 will be replaced with a new air vent and secured properly.</p> <p>1f. The heating floor vent outside room #221 will be replaced with a new heating floor vent and properly secured to the wall.</p> <p>1g. The handrails outside of rooms #127 and 129 will have the exposed nails removed and new finish nails put in their place. The nail holes will be filled and sanded. The handrail will then be refinished.</p> <p>1h. Room #110 will have new covers installed to hide the exposed orange colored pipes.</p> <p>2a. Room #208 will have the bathroom wall and the door sanded and repainted to remove the gouging and marring in these areas.</p> <p>2b. The bathroom ceiling vent in</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>gouged and marred.</p> <p>b.) Room #321 on 10/27/2015 at 10:17 a.m., the bathroom ceiling vent was falling out of the ceiling and wires were exposed.</p> <p>c.) Room #324 on 10/28/2015, at 10:21 a.m., the bathroom door and walls were gouged, marred, chipped and peeling, the bathroom door hinge was loose, the ceiling panel above the entrance doorway was bowed and loose, the bedroom walls were marred, chipped, gouged and peeling, and the light fixture above the bedroom entryway was not connected and screws were loose.</p> <p>d.) Room #328 on 10/27/2015 at 10:29 a.m., the bathroom walls and closet were gouged, marred, chipped and peeling, the bathroom vent over the toilet was loose and ceiling panels stained and peeling, bathroom door and archway was marred, chipped and peeling.</p> <p>e.) Room #405 on 10/27/2015 at 11:52 a.m., the bathroom and bedroom doors were gouged, chipped, marred and peeling, the closet door would not shut and the doors were marred and chipped.</p> <p>f.) Room #406 on 10/27/2015 at 12:03 p.m., the bedroom door and walls were</p>		<p>room #321 will be secured properly to keep in place.</p> <p>2c. Room #324 will have the bathroom walls and door sanded and repainted to eliminate the gouging, marring, chipping, and peeling. The bathroom door hinge will be properly secured. The ceiling panel above the entrance doorway will be replaced with a new panel that is secured properly. The bedroom walls will be sanded and repainted to eliminate the marring, chipping, gouging, and peeling. The light fixture above the entryway will be properly connected and all screws will be secured.</p> <p>2d. In room #328, the bathroom walls and closet will be sanded and repainted to eliminate all gouging, marring, chipping, and peeling. The bathroom vent over the toilet will be secured properly and the stained ceiling panels will be replaced. The bathroom door and archway will be sanded and repainted to remove all marring, chipping, and peeling.</p> <p>2e. Room #405 bathroom and bedroom doors will be sanded and repainted to eliminate the gouges, chips, marring, and peeling. New hardware will be installed on the closet door to enable it to close properly. The closet doors will also be sanded and repainted to remove all marring and chipping.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>marred, chipped, and gouged.</p> <p>g.) Room #408 on 10/27/2015 at 2:58 p.m., the outside window was broken, furniture was marred, chipped, and peeling, bathroom and bedroom doors were marred, chipped and peeling, 2 floor bedside mats located around the resident bed were ripped and shredded, the closet doors and bedroom walls were gouged, marred, chipped and peeling.</p> <p>h.) Room #411 on 10/27/2015 at 12:06 p.m., the bedroom and bathroom archways and furniture were marred, chipped, and peeling, the bedroom walls and door were marred, chipped, gouged and peeling, closet doors were uneven and closet door handles do not match.</p> <p>h.) Room #420 on 9/28/2015 at 3:09 p.m., the bedroom and bathroom doors and archways were marred, chipped, gouged and peeling, the bedroom walls were marred and chipped, the closet doors was marred, chipped and cracked, the bedroom tile entering the bathroom was chipped and cracked, the bathroom toilet seat water valves were broken and screw knobs were exposed and the over head light in the bedroom had dead bugs in the light.</p> <p>During the environmental tour with the</p>		<p>2f. Room #406 will have the bedroom door and walls sanded and repainted to eliminate all marring, chipping, and gouging.</p> <p>2g. Room #408 will have the broken window replaced by Kokomo Glass. The furniture in the room will be touched-up to eliminate the marring, chipping, and peeling. The bathroom and bedroom doors will be sanded and repainted. The old floor mats in the room will be replaced with new floor mats. The closet doors and bedroom walls will be sanded and repainted to eliminate all gouging, marring, chipping, and peeling.</p> <p>2h. Room #411 will have the bedroom and bathroom archways, walls, and doors sanded and repainted to repair all blemishes. The furniture will be touched-up to eliminate all marring, chipping, and peeling. The closet doors will be leveled and a matching set of door handles will be installed.</p> <p>2h. Room #420 will have the bedroom and bathroom doors and archways sanded and repainted to remove all blemishes. The bedroom walls and closet doors will be sanded and repainted to eliminate all marring, chipping, and cracking. The bedroom tile entering the bathroom will be replaced with a</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>Executive Director, and Maintenance Supervisor on 10/29/2015 at 1:30 p.m., the following were observed:</p> <p>a.) The hallway ceiling located outside of rooms #224 and 225, the ceiling fan was loose and not secured to the ceiling.</p> <p>b.) Room #110, the bedroom walls were marred, chipped and peeling, 3 ceiling panels had wet spots and ceiling panels were chipped and cracked, the bathroom door was chipped, gouged, and marred, and the closet door was chipped and cracked.</p> <p>c.) The wallpaper alongside the water faucet located outside the clean storage area near the dementia unit entrance was peeling and shredded.</p> <p>d.) The call lights located outside rooms #110, 130, 128, 127 and 205 had dead bugs contained inside the call lights.</p> <p>On 10/29/2015 at 2:30 p.m., the Executive Director indicated the facility had a reporting system for all staff to notify the maintenance department of facility needed repairs and housekeeping issues. The Maintenance Supervisor indicated he was not aware of the facility needing these repairs or that areas were in need of cleaning by housekeeping.</p>		<p>new tile. The bathroom seat water valves will be repaired and the screw knobs will be covered. The overhead light in the bedroom will be cleaned to remove all dead bugs within the cover.</p> <p>a. The ceiling fan located outside of rooms #224 and 225 in the hallway will be properly secured.</p> <p>b. Room #110 will have the bedroom walls sanded and repainted to eliminate all areas of marring, chipping, and peeling. The three ceiling panels with water spots will be replaced with new ceiling panels. The bathroom and closet doors will be sanded and repainted to eliminate all areas of chipping, gouging, marring, and cracking.</p> <p>c. The wall paper alongside the water faucet located outside the clean storage area on the dementia unit will be repaired to eliminate the peeling and shredding.</p> <p>d. The call lights located outside rooms #110, 130, 128, 127 and 205 will have the covers removed and cleaned.</p> <p>The Maintenance and Housekeeping Supervisors have developed a plan regarding procedures for reporting and entry of environmental issues into the Building Engines Service Request Maintenance System.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
---	---

(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>The policy titled "Work Order Submissions and Guidelines", dated 5/2014, received on 10/29/2015 at 4:01 p.m., from the Maintenance Supervisor indicated "...Overview, Use the information on this card to enter a request for non-scheduled maintenance into the Building Engines Service Request Maintenance System software. Beverly has implemented the new software to track both scheduled and non-scheduled maintenance tasks in the facilities"</p> <p>3.1-19(f)</p>		<p>The housekeepers are present in every resident room and common areas within the building daily. When they see an issue that needs to be entered into the Building Engines Maintenance System, they fill out a maintenance request. The request details the issue and the location where the service is needed. The Housekeeping Supervisor then enters the maintenance request into the Building Engines Maintenance System. The Maintenance Supervisor checks for new work orders within this system on a frequent basis throughout the day via a company issued iPod. These maintenance requests are then addressed in the order in which they are received to alleviate the environmental issues discovered within the facility.</p> <p>In order to gain better control of the preventative maintenance issues within the facility, the maintenance department has begun to use the preventative maintenance software within the Building Engines Service Request Maintenance System. This software generates and tracks all scheduled preventative maintenance tasks within the facility. These tasks include detailed painting, HVAC, generator, and various other life safety checks.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2015

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901		
(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	