

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534
---	--

(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
F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: October 14, 15, 16, and 17, 2014</p> <p>Facility Number: 000088 Provider Number: 155686 AIM Number: 100289260</p> <p>Survey Team: Heather Hite, RN - TC Regina Sanders, RN Julie Ferguson, RN (October 16 and 17, 2014) Janelyn Kulik, RN (October 14 and 17, 2014)</p> <p>Census Bed Type: SNF/NF: 54 Total: 54</p> <p>Census Payor Type: Medicare: 5 Medicaid: 41 Other: 8 Total: 54</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>4875 for 2014 Annual Survey: Preparation, submission and implementation of this plan does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. This Plan of Correction is prepared and executed as a means to continually to improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	

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: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534
---	--

(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
F000279 SS=D	<p>Quality review completed on October 20, 2014, by Janelyn Kulik, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review, observation, and interview, the facility failed to develop resident care plans related to the risk for bruising and bleeding for a resident taking Aspirin (a medication which can thin the blood) and Brilinta (a medication which prevents the blood from clotting), for 1 of 3 residents reviewed for non-pressure skin conditions of the 4 who met the criteria for non-pressure skin</p>	F000279	<p>F 279</p> <p>Step one: 1.) Care plan implemented for resident #80 for risk of bleeding and bruising related to use of aspirin and Brilinta implemented on 10/16/2014.</p> <p>Step two 1.) Audit will be completed on all residents who received an antiplatelet</p>	11/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>conditions. (Resident #80)</p> <p>Findings include:</p> <p>Resident #80's record was reviewed on 10/16/14 at 8:35 AM. Diagnoses included, but were not limited to, coronary atherosclerosis (hardening and narrowing of the arteries in the heart), epistaxis (nosebleed), hematuria (blood in the urine), and recent aortic artery aneurysm repair surgery.</p> <p>Current Physicians orders included the following medications:</p> <ul style="list-style-type: none"> - ASA (aspirin - a medication which can thin the blood) 81 mg (milligrams) 1 tablet by mouth in the morning for PVD (peripheral vascular disease). - Brilinta (a medication which prevents the blood from clotting) 90 mg 1 tablet by mouth two times a day related to coronary atherosclerosis. <p>Review of the Medication Administration Records (MARs) for September & October 2014 indicated Resident #80 received his ASA and Brilinta daily from 9/23/14 until present, with the ASA held only from 10/2 - 10/6/14.</p> <p>A professional resource, titled, "Nursing 2014 Drug Handbook", pages 1351-52, indicated, "Brilinta ... Black Box</p>		<p>or anticoagulant to ensure plan or care in place. Any deficiencies noted will be corrected.</p> <p>Step three</p> <ol style="list-style-type: none"> 1.) In-service for all Licensed Nurses related to initiating care plans for antiplatelet and anti coagulants to be completed. 2.) All new admission charts will be brought to am clinical meeting 5 times weekly for review of medications that require a care plan. 3.) New orders will be reviewed 5 times weekly by DNS and/or designee and care plan written. 4.) DNS and/or designee will audit residents that receive antiplatlet and/or anticoagulant weekly to ensure plan or care in place and will report findings to QA&A committee monthly for 6 months. <p>Step four</p> <ol style="list-style-type: none"> 1. The QA&A Committee will monitor for any trends monthly for 6 months and will determine the need for further and/or ongoing monitoring. The Committee will also make any recommendations and/or changes to the plan of correction. <p>Completion date 11/16/2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>Warning: Drug can cause serious, sometimes fatal bleeding ..."</p> <p>The resident's record lacked a care plan addressing the bleeding and bruising risk presented by use of the medications ASA and Brilinta.</p> <p>During an observation on 10/14/2014 at 11:36 AM, a fading reddish - purple discoloration was noted to Resident #80's left forearm. He was confused and unable to answer questions at this time.</p> <p>During an observation on 10/16/14 at 8:30 AM, a fading reddish - purple area was noted to Resident #80's left forearm. He was alert and indicated, "I think I've had that one for awhile." Two new dark purple areas were noted at this time, one to the bend of each arm, which he indicated were from recent lab tests.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 10/16/2014 at 11:45 AM, indicated Resident #80 should have had a care plan for bleeding and bruising risk since admission due to taking the medications ASA and Brilinta. The interview further indicated she would implement that care plan immediately.</p> <p>3.1-35(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534
---	--

(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
--------------------	--	---------------	---	----------------------

F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the facility failed to ensure a resident's care plan and facility policy were followed, related to no assessment of the resident's anxiety and no prior interventions attempted before the administration of an anti-anxiety medication for 1 of 19 residents reviewed for care plans. (Resident #69)</p> <p>Findings include:</p> <p>Resident #69's record was reviewed on 10/17/2014 at 8:15 a.m. Resident #69's diagnoses included, but were not limited to, Alzheimer's disease and severe dementia with depressive features.</p> <p>The 60-Day Minimum Data Set Assessment, dated 10/01/14, indicated the resident's cognition was impaired, had physical behaviors and rejection of care one to three days in the past seven, and</p>	F000282	<p>F282</p> <p>Step one: 1.) Care plan implemented for resident #69 for use of Ativan on 10/17/2014 .</p> <p>Step two 1.) Audit will be completed on all residents who received a prn anti-anxiety to ensure plan or care in place. Any deficiencies will be noted and corrected.</p> <p>Step three 1.) In-service for all Licensed Nurses related to initiating care plans for anti-anxiety to be completed 2.) All new admission charts will be brought to an clinical meeting 5 times weekly for review of medications that require a care plan. 3.) New orders will be reviewed 5 times weekly by DNS and/or designee and care plan written as per protocol. 4.) DNS and/or designee will audit residents that receive prn anti-anxiety</p>	11/16/2014
-----------------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>received an anti-anxiety medication once in the past seven days.</p> <p>A care plan, dated 08/11/14, indicated the resident had behaviors which included, hitting during care and disruptive to others related to repetitive statements. The interventions included, attempt interventions before the behavior begins, medications as the Physician has ordered, ensure the resident was not in pain or uncomfortable, offer nap, toileting, and one on one visits.</p> <p>A Physician's Order, dated 08/04/14, indicated an order for, Ativan (anti-anxiety) 1 mg (milligram) every eight hours as needed for anxiety.</p> <p>The Medication Administration Record (MAR), dated 09/14, indicated the resident received the as needed Ativan on the following dates:</p> <p>On 09/01/14 at 3:23 p.m., the Nurses' Note for this date and time indicated the medications was given for anxiety. There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was not documented on the Behavior Monthly Flow Sheet or the Behavioral Detail Report.</p>		<p>weekly to ensure plan or care in place and will report findings to QA&A committee monthly for 6 months.</p> <p>Step four 1. The QA&A Committee will monitor for any trends monthly for 6 months and will determine the need for further and/or ongoing monitoring. The Committee will also make any recommendations and/or changes to the plan of correction.</p> <p>Completion date 11/16/2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>On 09/02/14 at 3:02 p.m., the Nurses' Note for this date and time indicated the medications was given for anxiety. There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was not documented on the Behavior Monthly Flow Sheet or the Behavioral Detail Report.</p> <p>On 09/03/14 at 4:40 p.m., the Nurses' Note for this date and time indicated the medications was given for anxiety. There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was not documented on the Behavior Monthly Flow Sheet or the Behavioral Detail Report.</p> <p>On 09/26/14 at 5:06 p.m., the Nurses' Note for this date and time indicated the medication was given for, "resident upset". There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was documented on the Behavior Monthly Flow Sheet and the Behavioral Detail Report and lacked</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534		
(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>documentation to indicate what interventions were used prior to the administration of the medication.</p> <p>The MAR, dated 10/14, indicated the Ativan 1 mg was given on 10/03/14 at 3:34 p.m. The Nurses' Note for this date and time indicated the medications was given for anxiety. There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was not documented on the Behavior Monthly Flow Sheet or the Behavioral Detail Report.</p> <p>During an interview on 10/17/14 at 12:23 p.m., with the Director of Nursing (DON) and the Social Service Director (SSD), the DON indicated the staff were to attempt different interventions prior to the administration of the as needed medication. The SSD indicated there were no assessments of the signs and symptoms of the anxiety on the above dates when the as needed Ativan had been administered.</p> <p>A facility policy, dated 2013, titled, "Behavior Management Guideline", received from the DON as current, indicated, "...The Antecedent Behavior Monitoring Log is</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534
---	--

(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
F000309 SS=D	<p>utilized...Non-pharmacological interventions and implemented and assess for effectiveness, PRIOR to considering initiation of any psychoactive medications...The use of any medication to control behaviors should always be considered a last resort to assist with managing a resident's behavior..."</p> <p>3.1-35(g)(2)</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 observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the assessment and monitoring of bruises for 2 of 3 residents reviewed for non pressure related skin conditions of the 4 residents who met the criteria for non</p>	F000309	<p>F 309</p> <p>Step one: 1.) Head to toe skin assessment completed for resident # 69 and #80 by License Nurse. Skin sheet completed 2.) MD and family notified.</p> <p>Step two 1.) Skin sweep initiated on all</p>	11/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534		
(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>pressure related skin conditions. (Residents #80 and #61)</p> <p>Findings include:</p> <p>1. During an observation on 10/14/2014 at 11:36 AM, a fading reddish - purple discoloration was noted to Resident #80's left forearm. He was confused and unable to answer questions at this time.</p> <p>During an observation on 10/16/14 at 8:30 AM, a fading reddish - purple area was noted to Resident #80's left forearm. He was alert and indicated, "I think I've had that one for awhile." Two new dark purple areas were noted at this time, one to the bend of each arm, which he indicated were from recent lab tests.</p> <p>Resident #80's record was reviewed on 10/16/14 at 8:35 AM. Diagnoses included, but were not limited to, coronary atherosclerosis (hardening and narrowing of the arteries in the heart), epistaxis (nosebleed), hematuria (blood in the urine), and recent aortic artery aneurysm repair surgery.</p> <p>Current Physicians orders included the following medications: - ASA (aspirin - a medication which can thin the blood) 81 mg (milligrams) 1 tablet by mouth in the morning for PVD</p>		<p>resident on 10/16/2014 and completed on 10/17/2014. Any deficiencies noted were corrected.</p> <p>Step three 1.) In-service for all Licensed Nurses and CNA's related to reporting discolorations and area of concerns to Licensed Nurse. Documentation of areas of concerns on shower sheets. Shower sheets to be given to Licensed Nurses. Licensed Nurses to review and turn in signed shower sheets to DNS and/or designee. In-service to be completed. 3.) DNS and/or designee will review shower sheets 5 times weekly for 2 months then weekly for 4 month. 4.) DNS and/or designee will observe 4 residents weekly for any skin issues and will report findings to QA&A committee monthly for 6 months.</p> <p>Step four 1. The QA&A Committee will monitor for any trends monthly for 6 months and will determine the need for further and/or ongoing monitoring. The Committee will also make any recommendations and/or changes to the plan of correction.</p> <p>Completion date 11/16/2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>(peripheral vascular disease). - Brilinta (a medication which prevents the blood from clotting) 90 mg 1 tablet by mouth two times a day related to coronary atherosclerosis.</p> <p>Review of the Medication Administration Records (MARs) for September & October 2014 indicated Resident #80 received his ASA and Brilinta daily from 9/23/14 until present, with the ASA held only from 10/2 - 10/6/14.</p> <p>Review of the nursing Clinical Health Status (admission) assessment dated 9/22/14 indicated skin conditions of surgical wounds to the right and left groin areas and the mid-abdomen. The assessment lacked documentation of any bruising or discoloration to the left forearm.</p> <p>Review of the Wound Evaluation Flow Sheets indicated the monitoring of the groin and abdominal surgical wounds starting 9/22/14, but lacked any documentation of bruising or discoloration to the left forearm. A monitoring sheet was started for the two discolored areas to the inner elbows on 10/15/14.</p> <p>Review of the Progress notes since admission lacked documentation or</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>monitoring of any bruising or discoloration to Resident #80's left forearm.</p> <p>Interview with Resident #80's daughter on 10/16/2014 10:15 AM, indicated reddish - purple discoloration to his left forearm occurred in the hospital and was present upon admission to the facility. She also indicated the two new bruises to his arms were from recent lab tests.</p> <p>Interview with LPN #1 on 10/16/14 at 9:00 AM, indicated she was fairly certain Resident #80 was admitted with the bruised area to his forearm and also had two new bruises to the inner elbow area from recent lab tests. She further indicated the bruised area to his forearm should have been noted on the admission assessment, a skin sheet started, and he should have been monitored, "especially since he has had bleeding issues for which we have had to send him over to the hospital 2 or 3 times since his admission in September."</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 10/16/2014 at 9:15 AM, indicated recent bruises being monitored were to the inner elbow area of both arms from labs done when he was sent to hospital on the evening of 10/14/14 and any other bruising should</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>have been monitored already in the nurses' charting or skin sheets.</p> <p>2. During a resident observation on 10/15/2014 at 08:28 a.m., the back of the resident's left hand was observed to have a small reddish - purple area.</p> <p>Resident #61's record was reviewed on 10/16/14 at 10:31 a.m. The resident's diagnoses included, but were not limited to, memory loss, dementia, dizziness and giddiness, depression and Parkinson's Disease (tremors, shaking).</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 8/29/14, indicated the resident was cognitively impaired and required extensive assistance of two people for transfers, dressing, toilet use, and bed mobility.</p> <p>The Physician's Order Summary, dated 10/14, indicated the resident did not have a medication ordered which could thin the blood.</p> <p>A "Wound Evaluation Flow Sheet" lacked documentation of the reddish - purple discoloration of the back of the left hand, until the a.m. of 10/17/14. The following non-pressure documentation was as follows: 10/17/14 Left hand between 2nd and 3rd knuckle: 0.8 X 0.5 cm (centimeters), purple and treatment to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>observe; 10/17/14 top left hand pinky side, 1.3 X 1.2 cm, purple, treatment to observe; 10/17/14 top left hand 3.5 X 1.5 cm, purple, treatment to observe; 10/17/14 top left hand, 1.0 X 1.0 cm purple, and treatment to observe; 10/17/14 top left hand, 1.0 X 1.0 cm purple, no treatment.</p> <p>There was a lack of documentation in the resident's progress notes regarding the reddish - purple discoloration of the back of the left hand.</p> <p>There was a lack of documentation to indicate an investigation for the cause of the discoloration had been completed.</p> <p>Interview with the Administrator on 10/17/14 at 8:30 a.m. indicated the resident's reddish - purple spots on the back of his left hand were found this a.m. during a whole house sweep of residents' skin assessments.</p> <p>Interview with the DON (Director of Nursing) on 10/17/14 at 8:43 a.m., indicated the CNA should have reported the discoloration to the nurse during resident care. The nurse should have done a weekly skin assessment on Tuesday 10/15/14 of the resident's skin and measured anything existing or documented anything new.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534		
(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	
F000329	<p>The policy titled "Skin Integrity Guideline," was received from the DON on 10/17/14 at 9:30 a.m., and identified as current. The policy indicated the following: "Purpose: to provide a systemic approach for monitoring skin condition...DNS (Director of Nursing Services) or designee will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis...Documentation and Care Interventions for Skin Integrity:...Residents will be observed by the CNA daily for reddened/open areas, edema of feet or sacrum.. Changes will be reported to the licensed nurse and documented..."</p> <p>3.1-37(a)</p>				
	483.25(l)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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			
SS=D	<p>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 record review and interview the facility failed to ensure a resident was free from unnecessary medications and failed to ensure residents were monitored for medication use, related to no assessment of the resident's anxiety and no prior interventions attempted before the administration of an anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #69)</p> <p>Findings include:</p>	F000329	<p>F329</p> <p>Step one: 1.) MD and Family notified of medication given without prior assessment of need for Ativan and non pharmacological interventions attempted prior to administration.</p> <p>Step two 1.) Audit to be completed of all resident with whom receive prn anti-anxiety medications.</p> <p>Step three 1.) Licensed Nurses will be in</p>	11/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>Resident #69's record was reviewed on 10/17/2014 at 8:15 a.m. Resident #69's diagnoses included, but were not limited to, Alzheimer's disease and severe dementia with depressive features.</p> <p>The 60-Day Minimum Data Set Assessment, dated 10/01/14, indicated the resident's cognition was impaired, had physical behaviors and rejection of care one to three days in the past seven, and received an anti-anxiety medication once in the past seven days.</p> <p>A care plan, dated 08/11/14, indicated the resident had behaviors which included, hitting during care and disruptive to others related to repetitive statements. The interventions included, attempt interventions before the behavior begins, medications as the Physician has ordered, ensure the resident was not in pain or uncomfortable, offer nap, toileting, and one on one visits.</p> <p>A Physician's Order, dated 08/04/14, indicated an order for, Ativan (anti-anxiety) 1 mg (milligram) every eight hours as needed for anxiety.</p> <p>The Behavior Monthly Flow Sheet, dated 09/14, indicated the resident was monitored for kicking, pinching, scratching, slapping, striking out/hitting,</p>		<p>serviced on proper procedure regarding use of prn anti-anxiety medications to be completed.</p> <p>2.) Alternative to Drug Therapy Behavior Management form will be implemented.</p> <p>3.) DNS and/or designee will audit all residents with prn anti-anxiety medications 5 times weekly for 2 months, then weekly for 4 months. The findings will be reported to QA&A Committee monthly for 6 months</p> <p>Step four 1. The QA&A Committee will monitor for any trends monthly for 6 months and will determine the need for further and/or ongoing monitoring. The Committee will also make any recommendations and/or changes to the plan of correction.</p> <p>Completion date 11/16/2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534
---	--

(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>and yelling out/disruptive and repetitive statements. The flow sheet indicated the resident had all the behaviors once on 09/27/14 and 09/28/14. The form did not indicate the interventions used nor the outcome of the interventions.</p> <p>A Behavior Detail Report, dated 09/27/14 and 09/28/14, indicated the Licensed Nurse had been notified of the behaviors and the behaviors of verbal towards others and physical behavior towards others was not easily altered. The report did not indicate what interventions were attempted.</p> <p>The Medication Administration Record (MAR), dated 09/14, indicated the resident received the as needed Ativan on the following dates:</p> <p>On 09/01/14 at 3:23 p.m., the Nurses' Note for this date and time indicated the medications was given for anxiety. There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was not documented on the Behavior Monthly Flow Sheet or the Behavioral Detail Report.</p> <p>On 09/02/14 at 3:02 p.m., the Nurses' Note for this date and time indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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>medications was given for anxiety. There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was not documented on the Behavior Monthly Flow Sheet or the Behavioral Detail Report.</p> <p>On 09/03/14 at 4:40 p.m., the Nurses' Note for this date and time indicated the medications was given for anxiety. There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was not documented on the Behavior Monthly Flow Sheet or the Behavioral Detail Report.</p> <p>On 09/26/14 at 5:06 p.m.,the Nurses' Note for this date and time indicated the medication was given for, "resident upset". There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was documented on the Behavior Monthly Flow Sheet and the Behavioral Detail Report and lacked documentation to indicate what interventions were used prior to the administration of the medication.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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 MAR, dated 10/14, indicated the Ativan 1 mg was given on 10/03/14 at 3:34 p.m. The Nurses' Note for this date and time indicated the medications was given for anxiety. There was no documentation of an assessment of the anxiety, the symptoms of the anxiety, nor interventions provided prior to the administration of the Ativan. The behavior was not documented on the Behavior Monthly Flow Sheet or the Behavioral Detail Report.</p> <p>During an interview on 10/17/14 at 12:23 p.m., with the Director of Nursing (DON) and the Social Service Director (SSD), the DON indicated the staff are to attempt different interventions prior to the administration of the as needed medication. The SSD indicated there were no behaviors logged on the behavior monitoring forms, except for 09/27/14 and 09/28/14. The SSD indicated there were no assessments of the signs and symptoms of the anxiety on the above dates when the as needed Ativan had been administered. The SSD indicated the resident will usually calm down if you give her one on one and talk with her.</p> <p>A facility policy, dated 2013, titled, "Behavior Management Guideline",</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534			
(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			
F000441 SS=D	<p>received from the DON as current, indicated, "...The Antecedent Behavior Monitoring Log is utilized...Non-pharmacological interventions and implemented and assess for effectiveness, PRIOR to considering initiation of any psychoactive medications...The use of any medication to control behaviors should always be considered a last resort to assist with managing a resident's behavior..."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534		
(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>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to maintain proper infection control related to the storage and labeling of resident care items for 1 of 22 resident rooms observed. (Room 34)</p> <p>Findings include:</p> <p>During a room observation on 10/15/14 at 9:23 AM, the following was observed:</p>	F000441	F 441 Step one:1.) Items removed and disposed of on 10/17/2014. Step two:1.) Audit of all resident rooms conducted on 10/17/2014. No deficiencies noted. Step three:1.) In service Licensed Nurses and CNA's related to storage of personal care items to be completed. 2.) QA room rounds check off sheet to be implemented. 3.) DNS and/or designee will audit 4 resident rooms daily for 2 months, then weekly for 4 months. The findings will be	11/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534		
(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	
F000465 SS=E	<p>A.) A specimen collection pan was sitting uncovered and unlabeled with a resident name on the bathroom shelf of Room 34.</p> <p>B.) A tube of barrier cream was sitting on the bathroom shelf of Room 34 next to the specimen collection pan open and unlabeled with a resident name.</p> <p>This had the potential to affect the two residents who resided in Room 34.</p> <p>On 10/17/14 at 1:00 PM, during the environmental tour with the Administrator, Maintenance Director and Housekeeping Supervisor, the specimen collection pan was still observed uncovered on the bathroom shelf of Room 34. The barrier cream remained open and unlabelled with a resident name.</p> <p>At the time of the tour, the Administrator indicated the specimen collection pan should have been covered and labeled and the cream should have been capped and labeled.</p> <p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p>		<p>reported to QA&A Committee monthly for 6 months. Step four1. The QA&A Committee will monitor for any trends monthly for 6months and will determine the need for further and/or ongoing monitoring. The Committee will also make any recommendations and/or changes to the plan of correction. Completion date 11/16/2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534		
(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 facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to missing radiator covers, missing corner guards, holes in the walls, and stained and marred floors in 4 of 22 rooms throughout the facility. (Rooms W 9, W 22, E 23, & E 34). This had the potential to affect 7 residents residing in those rooms.</p> <p>Findings include:</p> <p>During an environmental tour with the Administrator, Maintenance Director and Housekeeping Supervisor on 10/17/14 at 1:00 PM, the following were observed:</p> <p>1. West Wing</p> <p>a. The corner guard was missing to the wall between the sink & shower in the bathroom of Room 9, leaving a sharp edge. One resident resided in this room.</p> <p>b. The bathroom radiator cover was missing in Room 22, leaving sharp edges exposed. Two residents resided in this room.</p> <p>2. East Wing</p>	F000465	<p>F465 1. Corner guard on wall in Room 9 bathroom installed on 10-27-2014. Radiator cover replaced on bathroom radiator in Room 22 on 10-27-2014. Wall under window in room 23 in process of replacement/repair. Hole in wall behind bed 2 in Room 34 repaired and repainted on 10-31-2014. Room 34 floor on schedule for strip and wax to remove spots and scrape on floor. 2. 100 % room audit to be completed. Any identified repair concerns will be entered into the Building Engine program for timely maintenance. 3. All resident rooms and bathrooms will be inspected weekly by designated staff and subsequently reported to the Executive Director. All identified repairs will be entered into the Building Engine program for timely maintenance. 4. Resident room and bathroom inspection will occur 1 time weekly for 4 months. After 4 months of review without any patterns or trends noted, inspections will occur 2 times monthly. Inspection results will be reviewed monthly for 6 months by the QAPI committee. 5. Completion date: 11-16-2014.</p>	11/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534		
(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>a. The plaster to the wall under the window in Room 23 was bulging. Two residents resided in this room.</p> <p>b. In Room 34, there was a hole in the wall behind bed 2, there was a dried brownish substance on the floor by the bathroom, and a scraped area by the foot of bed 2. Two residents resided in this room.</p> <p>Interview with the Administrator at the time of the tour, indicated all of the areas were in need of cleaning, repair, or replacement.</p> <p>3.1-19(f)</p>				