

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 8, 9, 10, 11, 14, 2014</p> <p>Facility number: 000033 Provider number: 155375 AIM number: 100266280</p> <p>Survey team: Dorothy Watts, RN TC Terri Walters, RN Amy Wininger, RN (7/8, 7/9, 7/10/, 7/14, 2014) Sylvia Scales, RN (7/8, 7/9, 7/10/, 7/14, 2014)</p> <p>Census bed type: SNF/NF: 56 Total : 56</p> <p>Census payor type: Medicare: 3 Medicaid: 46 Other: 7 Total: 56</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 17, 2014 by Jodi Meyer, RN</p>	F000000		
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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.

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review, the facility failed to ensure a dependent resident requiring assistance and/or cueing to perform activities of daily living (ADL'S) was provided assistance, in that a cognitively impaired resident was observed to have food debris and strong odor emanating from the mouth during 3 of 5 survey days. This deficient practice affected 1 of 6 residents who met the requirements for review of ADL care. (Resident #75)</p> <p>Findings include:</p> <p>Resident #75 was observed to have food debris and a strong odor emanating from the mouth on the following days and times: 7/8/14 at 11:15 A.M., and at 3:10 P.M., 7/9/14 at 9:15 A.M., and 7/10/14 at 1:30 P.M.</p> <p>On 7/10/14 at 1:30 P.M., Resident #75 indicated she would like to brush her teeth, but she did not have a toothbrush. During an interview at the same time, CNA #3 indicated that the entire unit's</p>	F000312	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>All residents on the Alzheimer's Care Unit have the potential to be affected by this deficient practice: Resident #75 was provided by facility a toothbrush for her oral care.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents on the Alzheimer's Care Unit have the potential to be affected by this deficient practice. Facility purchased two hanging storage containers to place residents personal hygiene items in the shower storage area. Each resident has their own designated compartment.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>	07/29/2014
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	<p>residents' personal supplies were kept in a personal supply closet for safety. CNA #3 indicated Resident #75 required assistance with setup and also required cueing and supervision during performance of her activities of daily living (ADL'S) which included oral care. CNA #3 further indicated she would get Resident #75's toothbrush. CNA #3 was observed to be unable to locate a toothbrush belonging to Resident #75.</p> <p>The Clinical Record for Resident #75 was reviewed on 7/10/14 at 1:49 P.M., and diagnoses include, but were not limited to, Alzheimer's disease, dementia, and hypertension.</p> <p>The care plans included, but were not limited to, impaired cognition, and risk for falls was initiated 7/2/14. Self care impairment, which was initiated 7/10/14, the goals included, but were not limited to, resident to washing of face, hands and torso daily, and groom self with set up help and supervision. Interventions included, but were not limited to, staff to cue resident to brush teeth and provide assistance when needed for personal hygiene.</p> <p>3.1-38(b)(1)</p>		<p>Central Supply Clerk or Designee will inspect weekly or as needed, residents personal compartment to ensure that proper supplies, i.e. toothpaste, toothbrush, shampoo etc. are available for use and marked with resident name.</p> <p>ACU Director or designee will in-service staff by 7/29/14 on new procedure for retaining personal care items in shower storage area.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Central Supply Clerk or Designee will inspect by audit tool 2 times weekly for 4 weeks then weekly for 8 weeks, residents personal compartment to ensure that proper supplies, i.e. toothpaste, toothbrush, shampoo etc. are available for use and marked with resident name. This will be monitored through facility QAPI monthly meeting times 3 months then quarterly times 3 then as needed.</p> <p>Date the systemic changes will be completed: 7/29/14</p>				

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F000371 SS=F	<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</p> <p>Based on observation, interview, and record review, the facility failed to ensure the adequate testing of sanitation solution and that appropriate dishwasher temperatures and/or sanitary practices were maintained in the dietary department during 2 of 2 kitchen tours. This potentially affected 54 of 56 residents who received meals from the facility kitchen.</p> <p>Findings include:</p> <p>On 7/8/14 beginning at 9:35 A.M., the following was observed on initial tour of the facility:</p> <p>1. In the food storage room the edges of the floor and the floor under the shelving units had black soil, dried food particles, and dust when a hand swipe was performed. The Food Service Manager</p>	F000371	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Food Storage Room floor and plastic containers on shelving have been cleaned. Metal exit door and door facing in storage room has been repaired. Correct sanitizing strips and procedure has been posted above 3 compartment sink. Dish machine was evaluated by Maintenance Director and booster heater was operating correctly. Sanitizing solution buckets were emptied and replaced with correct PPM solution. Floor under metal cabinet unit in kitchen area cleaned.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>Food Storage Room floor and metal cabinet unit will be cleaned daily</p>	07/29/2014
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	<p>(FSM) agreed, at that time, that the floor was soiled. Four large plastic containers on shelving contained bread crumbs, peas, and sugar. The lids of the containers were sticky with food particles. Spice containers of oregano, thyme, and ground basil also on shelving in the food storage area had lids with soiling of food debris. A metal exit door in the food storage room had rusted areas noted in the lower six inches of the bottom panel of the door. The lower 3 inches of the door facing was soiled with black dirt.</p> <p>2. On 7/8/14 at 9:45 A.M., one bucket of the sanitizing solution for food contact surfaces was tested by the FSM. She indicated there were 2 different strips the facility used for testing. There were QT-40 strips and QAC strips. The FSM at that time tested the solution using a QT- 40 strip in the solution for approximately 10 seconds. She indicated she wanted a reading of 200 ppm (parts per million). The reading was 200 ppm. The FSM then used a QAC strip and tested the solution by holding the strip in the solution approximately 10 seconds. The strip did not match the 3 color strips (100, 200, 300 ppm) on the label of the QAC container. Dietary Staff #1 at that time indicated to the FSM the QAC strips were to be used to check the sanitizing</p>		<p>with weekly deep clean schedule. Plastic containers will be put on a weekly cleaning schedule. Dish machine temperatures will be monitored by dish temperature logs 3 times daily and also by DSM or designee daily with monitoring tool. Sanitizing solution logs will be checked three times per day prior to each meal service and also by DSM or designee daily with monitoring tool. Dietary associates will be in serviced on these new procedures by 7/29/14.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Food Storage Room floor and metal cabinet unit will be cleaned daily with weekly deep clean schedule. Plastic containers will be put on a weekly cleaning schedule. Dish machine temperatures will be monitored by dish temperature logs 3 times daily and also by DSM or designee daily with monitoring tool. Sanitizing solution logs will be checked three times per day prior to each meal service and also by DSM or designee daily with monitoring tool. Dietary associates will be in-serviced on these new procedures by 7/29/14.</p> <p>How the corrective action will be monitored to ensure the deficient</p>				

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	<p>solution. The FSM then placed another QAC strip approximately 10 seconds in the sanitizing solution. The reading of the strip did not match the color strips on the label of the QAC bottle. The FSM was then made aware on the bottle label of the QAC strips instructions included to hold the strip in solution for 90 seconds. The FSM then applied a new QAC strip to the sanitizing solution for approximately 90 seconds and the reading was 400 ppm. The FSM indicated that was the reading she wanted.</p> <p>3. On 7/8/14 at 10:00 A.M., Dietary Staff #1 was observed preparing food on a metal cabinet unit in the kitchen area. A hand swipe under the unit and under other kitchen shelving units and around the edges of the kitchen floor indicated brown soil and food debris. The FSM agreed the floor was soiled. She also indicated at that time that 2 dietary staff had called in yesterday and 1 staff member had called in today.</p> <p>On 7/11/14 beginning at 9:50 A.M., the following was observed:</p> <p>4. Dietary staff #2 was observed using the dishwasher. She ran a load of plate covers through the dishwasher. The wash cycle temperature reading was 160 F (Fahrenheit) and the rinse cycle</p>		<p>practice will not recur, i.e., what quality assurance program will be put into place: Dietary cleaning schedule, dish machine and sanitation solution logs will be monitored by the DSM or designee using the monitoring tool 5 times per week for 4 weeks the 3 times per week for an addition 8 weeks. This will be monitored during the facility monthly QAPI meeting for 3 months then quarterly for an additional 9 months.</p> <p>Date the systemic changes will be completed: 7/29/14</p>	

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	<p>temperature reading was 178 F. She indicated at that time she wanted the wash cycle to be 150 F and the rinse cycle to be 180 F. Dietary Staff #2 then ran a load of trays through the dishwasher. The wash temperature reading was 161 F and the rinse temperature reading was 172 F. Dietary Staff #2 at that time indicated she hadn't checked the dishwasher temperatures that A.M. She then repeated previous loads through the dishwasher and the temperature readings were 160 F wash cycle and 170 F for the rinse cycle. Dietary Staff #1 indicated, at that time, the facility had trouble with the dishwasher temperatures last week. The maintenance man at that time was present and indicated to wait a few minutes between each load. He indicated that would allow the heater of the dishwasher to boost back up. Dietary Staff #2 waited approximately 5 minutes and then repeated the previous loads through the dishwasher. The wash cycle reading was 168 F and the rinse cycle reading was 185 F. During an interview at that time, Dietary Staff #2 indicated they were unaware of the problem with the dishwasher temperatures last week and the need to wait a few minutes before running different loads through the dishwasher.</p>			

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	<p>5. During an interview with the FSM on 7/11/14 at 10:10 A.M., she indicated the facility used both the QAC strips and the QT-40 strips. The food contact sanitizing solution was checked by the FSM using the QT-40 strips. The FSM indicated at that time the solution reading needed to be 300 ppm. The solution reading did not register on the 150 to 500 color chart on the QT-40 strip container. The FSM at that time prepared more sanitizing solution and rechecked the solution using a QT-40 strip. The reading was now 200 ppm. The FSM indicated at that time the sanitizing solution needed to be 300. The FSM then used the QAC strips tested the solution by holding the strip for approximately 90 seconds in the sanitizing solution. The solution reading was 400 ppm and she indicated she wanted the solution to be 300 ppm. The FSM indicated at that time she was discarding the QT-40 strips and the facility would use the QAC strips.</p> <p>6. The facility dish machine temperature log for July 2014 was reviewed on 7/11/14 at 11:55 A.M. The breakfast and lunch rinse temperatures recorded on the dates of 7/7/14, 7/8/14, 7/9/14, and 7/10/14 were readings below 180 F. The rinse temperature on 7/7/14 breakfast was 176 F and lunch rinse reading was 176 F.</p>			

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	<p>The 7/8/14 breakfast rinse temperature recorded was 172 F and the lunch rinse temperature reading was 178 F. The 7/9/14 breakfast rinse temperature recorded was 172 F and the lunch rinse reading was 176 F. The 7/10/14 breakfast rinse reading was 172 F and the lunch rinse cycle reading was 178 F.</p> <p>7. During an interview with the FSM and the Dietitian on 7/14/14 at 9:09 A.M., the Dietitian indicated the facility would now use the QT- 40 strips and not the QAC strips to test the sanitizing solution. The Dietitian was made aware at that time of the rinse temperatures registering below 180 F logged (dish machine temperature log) on 7/7/14, 7/8/14, 7/9/14, and 7/10/14.</p> <p>8. On 7/11/14 at 11:55 A.M., the facility policy entitled "Dish Machine Use and Care (policy date 2011)" was reviewed. The policy included but was not limited to, "... RINSE- Temperature must be maintained at a minimum of 180 F..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to ensure housekeeping services were provided to maintain the facility in a sanitary condition in that a resident's room located on the Alzheimer's Unit had a pervasive odor of urine on survey days 7/8/14, 7/9/14, 7/10/14, and 7/11/14.</p> <p>Resident #9, Resident #48, Resident # 39</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 7/8/14 at 11:07 A.M., Resident # 9 was observed lying on a low bed in his room with a strong urine odor noted. On 7/9/14 at 9:02 A.M., Resident #9 was observed in bed in his room with a strong urine odor noted. On 7/10/14 at 9:37 A.M., Resident #9 was observed sitting in his wheelchair in his room. A strong urine odor was present at that time.</li> <li>On 7/10/14 at 9:42 A.M., CNA #1 was observed assisting Resident #9 from his wheelchair to the commode. Resident</li> </ol>	F000465	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #9 cushion on wheelchair was cleaned. Resident #9 room deep cleaned including the air-conditioner vent. Carpet in front of room was cleaned. Resident #9 shoes were taken off wheelchair cushion.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All rooms have the potential to be affected by the same deficient practice. Facility Executive Director, Maintenance Director and ABM Housekeeping supervisor inspected all resident rooms and identified specific rooms that we consider "Extra Care Rooms" where there is a potential of urine odors. Wheelchair cushions are washed weekly per schedule. Cushions that are soiled due to resident incontinence will be washed before resident is placed back in wheelchair.</p>	07/29/2014

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	<p>#9's sweat pants were observed to be urine soaked. The resident was assisted to the toilet and pericare was provided. Clean sweat pants were applied and the resident was assisted back into his wheelchair and pushed to his bedside. Resident #9 was then assisted into bed. After care had been provided, the resident's shoes were placed in the seat of his wheelchair and the wheelchair remained in his room. No cleaning of the wheelchair cushion was provided after the resident had been incontinent of urine. A strong urine odor remained in the room at that time.</p> <p>3. On 7/11/14 at 8:55 A.M., Resident #9 was observed in bed with a strong urine odor noted in the resident's room and in the hall. CNA # 1 was interviewed at that time and indicated there was a strong urine odor in Resident #9's room and in the hall area of Resident #9's room. A carpet mat was observed at the door entrance of Resident #9's room and a large black stain in the hall carpet was observed under the carpet mat. CNA #1 indicated the facility had tried bleach and other cleaners to remove the urine stain and odor in the room and hall area. She also indicated the Alzheimer's unit hall carpet was to be replaced soon related to the urine odor.</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>ABM Housekeeping/Laundry Services will supply a cleaning solution that is a compound to neutralize urine. This can be used on any surface. This chemical will be used along with regular cleaning materials. Construction of new flooring began 7/22/14 on ACU's corridors. Cushions that are soiled due to resident incontinence will be washed before resident is placed back in wheelchair. Shoes will not be placed in wheelchairs.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Executive Director, Maintenance Director, Housekeeping Supervisor, ACU Director or designee will monitor 5 times weekly for 4 weeks, 2 times weekly for 4 weeks, 1 times weekly for 4 weeks then quarterly for an additional 9 months.</p> <p>Date the systemic changes will be completed: 7/29/14</p>				

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	<p>4. During an interview with CNA #1 on 7/11/14 at 11:40 A.M., she indicated a housekeeper had just cleaned the air conditioner/heating unit in Resident #9's room. She indicated the housekeeper had cleaned the vents of the unit. She indicated the unit had been cleaned because Resident #9's roommate, Resident #48, had voided in the heating/cooling unit.</p> <p>On 7/11/14 at 11:42 A.M., Housekeeping Staff #1 indicated she had just cleaned Resident #9's room related to the urine odor. She indicated she had cleaned the doorway of the room and the wall area by the heating and cooling unit and also the vents of the heating and cooling unit.</p> <p>5. On 7/14/14 at 9:52 A.M., the Alzheimer Unit Director was interviewed regarding the urine odor in Resident #9's room and the hall area. She indicated at that time staff made her aware of the continued urine odor in Resident 39's room and the hall carpet area. The Alzheimer Unit Director was made aware at that time of Resident #9's w/c cushion not been cleaned after he had been incontinent of urine in his wheelchair on 7/10/14 at 9:42 A.M. The Alzheimer Unit Director indicated the wheelchair cushion should have been cleaned at the time of the incontinence even though the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>wheelchair was scheduled to be cleaned routinely by night shift staff.</p> <p>On 7/14/14 at 10:20 A.M., the Housekeeping Supervisor was interviewed regarding cleaning on the Alzheimer's unit. She provided a daily cleaning schedule and a weekly deep cleaning schedule for the Alzheimer's unit. The schedule included, but was not limited to, a daily cleaning of each resident's room on the unit and other rooms on the unit, such as the dining room and the soiled /clean utility room. The schedule also included a section entitled "Extra Care Rooms." The Housekeeping Manager indicated Resident #9's room needed to be included in the extra care rooms due to frequent urine odors.</p> <p>3.1-19(f)</p>			
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