

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/06/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-WOODBRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 816 N FIRST AVE EVANSVILLE, IN47710
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F0000	<p>This visit was for a Post Survey Revisit [PSR] to the Recertification and State Licensure Survey completed on November 22, 2011.</p> <p>Survey dates: January 5, and 6, 2012</p> <p>Facility number: 000438 Provider number: 155390 AIM number: 100274170</p> <p>Survey team: Amy Wininger, RN, TC Diane Hancock, RN Vickie Ellis, RN Barbara Fowler, RN</p> <p>Census bed type: SNF/NF: 55 Total: 55</p> <p>Census payor type: Medicare: 3 Medicaid: 49 Other: 3 Total: 55</p> <p>Sample: 8</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p><b>Preparation and submission of this Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.</b></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.

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F0282 SS=D	Quality review completed 1/10/12 Cathy Emswiller RN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F0282	<b>F282</b> The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R56's medical record and discharge orders were reviewed, transcribed and implemented. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Any other residents that had had outpatient surgery had medical records reviewed to ensure that orders had been transcribed and implemented correctly. Licensed staff will receive in-service training by January 31, 2012 concerning following discharge instructions after surgery. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: DNS/Designee will review any orders from outpatient surgery daily to	02/01/2012	

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	Based on observation, interview, and record review the facility failed to ensure		<p><b>ensure the orders were transcribed and implemented using the match back procedure. Licensed staff will receive in-service training by January 31, 2012 concerning following discharge instructions after surgery. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</b></p> <p><b>DNS/Designee will audit the results of the match back procedure three (3) times a week for four (4) weeks, then two (2) times a week for three (3) months, to ensure orders are being transcribed correctly.</b></p> <p><b>The data will be analyzed for patterns and trends and action plans will be written and implemented as needed</b></p> <p><b>DNS/Designee will review the results of the match back procedure, trends, and action plans, and report findings at monthly QA meetings for three (3) months. The QA Committee will evaluate and compliance with F-282 via the monthly DNS/Designee reports.</b></p> <p><b>QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months.</b></p>	

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	<p>a resident received care as recommended following a procedure in that, Resident #56 returned from an oral surgery and the discharge instructions were not followed for 1 of 8 resident reviewed for following the plan of care in a sample of 8. [Resident #56]</p> <p>Findings include:</p> <p>The clinical record of Resident #56 was reviewed on 1/5/12 at 11:55 A.M.</p> <p>During the initial tour on 1/5/12 at 9:30 A.M., the MDS [Minimum Data Set Assessment] Coordinator indicated Resident #56 had experienced a whole mouth tooth extraction on 1/4/12.</p> <p>On 01/05/12 at 9:30 A.M., Resident #56 was observed lying in bed with a towel under his chin. At that time, Resident #56 was observed to have blood and saliva oozing from his mouth.</p> <p>On 01/05/12 at 11:05 A.M., Resident #56 was observed to be lying in bed. At that time, Resident #56 was observed to be moaning, had blood in his mouth, and blood was oozing from his mouth. At that time, no suction machine was observed in his room.</p> <p>On 01/05/12 at 12:15 P.M., Resident #56 was observed to receive a meal of warm, pureed food. At that time, CNA #1 was</p>				

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	<p>observed to place a clean towel under the chin of Resident #56.</p> <p>On 01/05/12 at 2:17 PM, Resident #56 was observed to be lying in bed with his mouth open. At that time, the mouth of Resident #56 was observed to have blood pooled near the gum line. At that time, no suction machine was observed to be in his room.</p> <p>On 01/05/12 at 2:33 PM, Resident #56 was observed to be lying in bed with a towel under his chin. At that time, no suction machine was observed in his room.</p> <p>The "Progress Notes" from 1/4/12 at 7:08 p.m., indicated the resident returned from the hospital following the full mouth teeth extraction. The "Progress Notes" on 1/4/12 at 10:00 PM, indicated Resident #56 "con't to drool saliva and blood from mouth, lower lip is slightly swollen and bruised. Mouth care given frequently, res. moans during care of mouth. Did give sips of thickened water."</p> <p>The discharge instructions dated 01/04/12 from [name of hospital] indicated, "...suction to ensure pt. does not choke..."</p> <p>The undated "Instructions Following Oral Surgery Procedures" form from [name of oral surgery group] indicated, "...apply a cold pack to your face over the operative</p>				

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	<p>site only for the first 24 hours...Apply for 30 minutes and leave off for 15-30 minutes...Gentle mouth rinsing with a diluted salt solution... is recommended four times a day..."</p> <p>During an interview on 1/5/12 at 11:05 A.M., LPN #1 indicated Resident #56 had full mouth extraction on 1/4/12 and resident had to have teeth cut out. LPN #1 indicated she had given resident oral care and pain medication and the left side of the resident's face was bruised from his surgery.</p> <p>During an interview of LPN #1 on 1/5/12 at 2:17 PM, LPN #1 indicated she had been following the discharge instructions from the hospital and had not followed any of the instructions from the [name of oral surgery group]. Upon query, at that time, LPN #1 indicated she had given Resident #56 oral care by swabbing out the mouth with gauze and water. At that time, LPN #1 indicated the resident had not received an ice pack to his face.</p> <p>On 01/05/12 at 2:33 P.M., LPN #1 was observed to apply an ice pack to the right side of Resident #56's face.</p> <p>During an interview on 01/5/12 at 3:05 P.M., Resident #56 indicated the ice made his face feel better.</p>			

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F0309 SS=D	<p>During an interview with the DoN on 01/05/11 at 4:00 P.M., he indicated that applying ice and rinsing the mouth after oral surgery were basic nursing measures. The DoN further indicated that a suction machine was located in the hall outside of the room of Resident #56. No suction machine was observed at any time outside the room of Resident #56.</p> <p>3.1-37(a)</p> <p>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. Based on observation, interview, and record review, the facility failed to manage pain and aftercare for 1 of 1 residents reviewed related to care following oral surgery from a sample of 8, in that, Resident #56 returned to the facility after having oral surgery and did not receive the recommended care. [Resident #56]</p>	F0309	<b>F309 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R56 had pain assessment updated immediately. R56 had a suction machine placed in his room and an ice pack applied. R56 threw the ice pack against the wall and refused application. Other residents having the</b>	02/01/2012	

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	<p>Findings include:</p> <p>The clinical record of Resident #56 was reviewed on 1/5/12 at 11:55 A.M.</p> <p>During the initial tour on 1/5/12 at 9:30 A.M., the MDS [Minimum Data Set Assessment] Coordinator indicated Resident #56 had experienced a whole mouth tooth extraction on 1/4/12.</p> <p>On 01/05/12 at 9:30 A.M., Resident #56 was observed lying in bed with a towel under his chin. At that time, Resident #56 was observed to have blood and saliva oozing from his mouth.</p> <p>On 01/05/12 at 11:05 A.M., Resident #56 was observed to be lying in bed. At that time, Resident #56 was observed to be moaning, had blood in his mouth, and blood was oozing from his mouth. At that time, no suction machine was observed in his room.</p> <p>On 01/05/12 at 2:17 PM, Resident #56 was observed to be lying in bed with his mouth open. At that time, the mouth of Resident #56 was observed to have blood pooled near the gum line. At that time, no suction machine was observed to be in his room.</p> <p>On 01/05/12 at 2:33 PM, Resident #56 was observed to be lying in bed with a towel under his chin. At that time, no suction machine was observed in his</p>		<p><b>potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Any other residents that had had outpatient surgery had medical records reviewed to ensure that orders had been transcribed and implemented correctly. Any resident receiving outpatient surgery will have pain assessment updated upon return to facility. Licensed staff will receive in-service training by January 31, 2012 concerning following discharge instructions after surgery. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: DNS/Designee will review any orders from outpatient surgery daily to ensure the orders were transcribed and implemented using the match back procedure. Licensed staff will receive in-service training by January 31, 2012 concerning following discharge instructions after surgery. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will audit the results of the match back</b></p>		

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	<p>room.</p> <p>The Nursing Progress Notes dated 1/4/12 at 7:08 p.m., indicated the resident returned from the hospital following the full mouth teeth extraction.</p> <p>The Nursing Progress Notes dated 1/4/12 at 10:00 PM, indicated Resident #56 "con't [continued] to drool saliva and blood from mouth, lower lip is slightly swollen and bruised. Mouth care given frequently, res. moans during care of mouth. Did give sips of thickened water."</p> <p>The discharge instructions dated 01/04/12 from [name of hospital] indicated, "...suction to ensure pt. does not choke..."</p> <p>The undated "Instructions Following Oral Surgery Procedures" form from [name of oral surgery group] indicated, "...apply a cold pack to your face over the operative site only for the first 24 hours...Apply for 30 minutes and leave off for 15-30 minutes...Gentle mouth rinsing with a diluted salt solution... is recommended four times a day..."</p> <p>During an interview on 1/5/12 at 11:05 A.M., LPN #1 indicated Resident #56 had full mouth extraction on 1/4/12 and resident had to have teeth cut out. LPN #1 indicated she had given resident oral care and pain medication and the left side</p>		<p><b>procedure and updating pain assessment of residents that have received outpatient surgery three (3) times a week for four (4) weeks, then two (2) times a week for three (3) months, to ensure orders are being transcribed correctly.</b></p> <p><b>The data will be analyzed for patterns and trends and action plans will be written and implemented as needed</b></p> <p><b>DNS/Designee will review the results of the match back procedure, trends, and action plans, and report findings at monthly QA meetings for three (3) months. The QA Committee will evaluate and compliance with F-309 via the monthly DNS/Designee reports.</b></p> <p><b>QA Committee will continue the audits until full compliance is achieved for three (3) consecutive months.</b></p>		

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	<p>of the resident's face was bruised from his surgery.</p> <p>During an interview of LPN #1 on 1/5/12 at 2:17 PM, LPN #1 indicated she had been following the discharge instructions from the hospital and had not followed any of the instructions from the [name of oral surgery group]. Upon query, at that time, LPN #1 indicated she had given Resident #56 oral care by swabbing out the mouth with gauze and water. At that time, LPN #1 indicated the resident had not received an ice pack to his face.</p> <p>On 01/05/12 at 2:33 P.M., LPN #1 was observed to apply an ice pack to the right side of Resident #56's face.</p> <p>During an interview on 01/5/12 at 3:05 P.M., Resident #56 indicated the ice made his face feel better.</p> <p>During an interview with the DoN on 01/05/11 at 4:00 P.M., he indicated that applying ice and rinsing the mouth after oral surgery were basic nursing measures. The DoN further indicated that a suction machine was located in the hall outside of the room of Resident #56. No suction machine was observed at any time outside the room of Resident #56.</p> <p>3.1-37(a)</p>				

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

PRINTED: 01/24/2012

FORM APPROVED

OMB NO. 0938-0391

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