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 04/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-WOODBRIDGE	816 N FIRST AVE EVANSVILLE, IN 47710

(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 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey Dates: 3/30/15, 3/31/15, 4/1/15, 4/6/15, 4/7/15 Facility Number: 000438 Provider Number: 155390 AIM Number: 100274170 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 5 Medicaid: 50 Other: 3 Total: 58 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 000	**Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any 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 conditionto participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.**	
F 241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to promote and/or provide dignity and privacy for each resident, in that, 3 of 6 residents observed receiving care did not have privacy curtains used and/or the staff entering the room did not knock or announce themselves. (Resident #13, Resident #47, Resident #26) Findings include: 1. During an observation on 3/30/15 at 2:15 p.m., Resident #13 was observed to be in his room with the door closed. CNA #1 was observed to open the resident's door and enter the room without knocking or announcing herself., 2. During an observation on 4/1/15 at 10:20 a.m., CNA #1 was observed to enter Resident #47's room for care. CNA #1 did not knock or announce herself prior to entering the room. CNA #1 provided pericare to Resident #47 without pulling the privacy curtain around the resident. Resident #47 shared the room with 2 (two) roommates. The roommate in bed "A" was lying in his bed, which was within eyesight of the resident who was receiving pericare.	F 241	**F 241 Staff were re-educated on the Dignity policy. Re-education of all staff was completed by 4/30/2015. An audit will be conducted by the DNS/Designee 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks and every other week for 4 weeks then 1 time per month for 3 months. The data will be analyzed for patterns and trends with action plans written and implemented as needed. DNS/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months. The QAPI Committee will evaluate compliance with F-241**	05/07/2015

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODBRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 816 N FIRST AVE EVANSVILLE, IN 47710	

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	3. During an observation on 4/6/15 at 10:56 a.m., LPN #2 entered Resident #26's room to administer a tube feeding. LPN #2 pulled the curtain between the resident's bed and bed 2 (two), but did not pull the curtain between bed (3) three and the resident, and/or between the resident and the room entrance door. During an interview on 4/7/15 at 8:41 a.m., CNA #4 indicated the staff should always knock and announce themselves prior to entering a resident's room. CNA #4 further indicated the curtains should be pulled and privacy should be provided to the residents when giving any care. A policy titled, "Dignity," effective 2/26/15 and obtained from the DON (Director of Nursing) on 4/7/15 at 10:35 a.m., indicated all residents will be treated in a manner that maintains each resident's dignity. The policy further indicated resident's space and property should be respected. 3.1-3(t)			

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F 272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on observation, interview, and record review, the facility failed to ensure	F 272	**F 272 For resident #47 MDS for Annual Assessment 8/4/14 indicated that the resident was edentulous. RNAC**	05/07/2015

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	comprehensive assessments were accurate in 2 of 4 residents sampled for dental issues, in a total sample of 14 who met the criteria. (Resident #47, Resident #55) Findings include: 1. During an observation on 3/31/15 at 9:55 a.m., Resident #47 was observed to have bottom teeth which were stained yellow and had food particles present. During an interview on 3/31/15 at 9:34 a.m., Resident #47 indicated he only had 5 (five) bottom teeth. The clinical record for Resident #47 was reviewed on 4/1/15 at 1:56 p.m. Resident #47 had diagnoses including, but not limited to, dementia, constipation, irritable bowel syndrome, convulsions, hypertension, obstructive hydrocephalus, mild intellectual disabilities, and neurofibromatosis. The annual MDS (Minimum Data Set) assessment, dated 8/4/14, indicated Resident #47 had a BIMS (Brief Interview for Mental Status) score of 9, indicating moderate cognitive impairment. The MDS assessment further indicated the resident did not have any natural teeth or tooth fragments and was edentulous.		**immediately corrected the MDS to show that the resident has teeth. Resident #55 was observed to have difficulty chewing. MDS annual assessment on 5/13/14 indicated no dental issues. RNAC immediately corrected MDS. RNAC will be re-educated on RAI coding procedures by Clinical Assessment Reimbursement Coordinator by 5/7/2015. Clinical Assessment Reimbursement Specialist (CAR)/ designee will perform audits on 1 complete and 3 quarterly MDS assessments per month for 3 months then (1) complete and two (2) quarterly MDS assessments for three (3) months then one (1) quarterly and one (1) annual MDS assessment for threee (3) months. The data will be analyzed for patterns and trends with action plans written and implemented as needed. The Clinical Assessment Reimbursement Specialist (CAR)/designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months The QAPI Committee will evaluate compliance with F-272**	

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	An "Oral Assessment" dated, 3/18/15, indicated Resident #47 had 16 (sixteen) missing and 9 (nine) mandibular teeth During an interview on 4/1/15 at 3:30 p.m., the MDS Coordinator indicated the MDS assessment was improperly entered on the annual assessment. 2. During an interview on 3/31/15 at 9:10 a.m., Resident #55 indicated he had difficulty chewing his food at times as his teeth were bad in the back. The clinical record of Resident #55 was reviewed on 3/31/15 at 4:03 p.m. Resident #55 had diagnoses including, but not limited to, late effect intracranial injury without mention skull fracture, dementia with behavioral disturbances, insomnia, alcohol dependence, epilepsy, hypertension, depressive disorder, mood disorder, iron deficiency anemia, amputation of the foot, and degenerative disc disease. An oral assessment, dated 3/18/15, indicated Resident #55 had 9 (nine) missing teeth and 2 (broken teeth). A "Comprehensive Oral Exam," dated 7/9/14, indicated Resident #55 needed an extraction or root canal treatment of tooth			

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	#9. The exam further indicated the tooth would be observed until it becomes problematic. An "Oral Assessment," dated 1/28/14, indicated Resident #55 had 9 missing teeth and 6 broken teeth. The annual MDS (Minimum Data Set) assessment, dated 5/13/14 and reviewed on 3/31/15 at 4:03 p.m., indicated Resident #55 did not have any dental issues. During an interview on 4/6/15 at 10:35 a.m., the MDS Coordinator indicated the assessment had been entered incorrectly. 3.1-31(c)(9)			
F 279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the			

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	assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on observation, interview, and record review, the facility failed to ensure 1 of 2 residents reviewed for urinary incontinence, in a total sample of 3 residents who met the criteria, had a comprehensive care plan including toileting and/or incontinent care. (Resident #9) Findings include: During an observation on 3/31/15 at 9:50 a.m., Resident #9 was observed to be at the nurse's station in clean clothes. LPN #1 indicated the resident had changed into clean clothes.	F 279	**F279 Resident #9 upon review of record was found to be missing a care plan for urinary incontinence. A care plan was immediately put in place of urinary incontinence by the RNAC. An audit of all incontinent resident charts was completed by the DNS/designee and any care plan discrepancies were addressed. An audit of all incontinent residents for utilization of a toileting plan will be completed 3 times per week for 2 weeks. 2 times per week for 2 weeks. 1 time per week for 1 month, 1 time bi-weekly for 1 month then montly for threee (3) months. The data will be analyzed for**	05/07/2015

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	During an interview on 4/1/15 at 10:04 a.m., LPN #1 indicated Resident #9 had been started on a bladder training program period and needed to be reminded to go to the bathroom. LPN #1 indicated the staff would remind the resident every 2 (two) hours to go to the bathroom and the resident would ambulate himself. The clinical record of Resident #9 was reviewed on 4/1/15 at 1:56 p.m. Resident #9 had diagnoses including, but not limited to, hemiplegia, urinary retention, dementia, chronic airway obstruction, dysphagia, cerebrovascular disease, chronic kidney disease, and hypertension. The quarterly MDS (Minimum Data Set) assessment indicated Resident #9 had a BIMS (Brief Interview for Mental Status) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #9 was an extensive assist of 1 (one) person for toilet use. The MDS further indicated Resident #9 was frequently incontinent and was on a urinary toileting program. The "Resident Continent Log," dated 1/15/15 - 4/1/15, indicated Resident #9 was incontinent 48 times. The clinical record lacked documentation of a care plan for incontinent care and/or		**patterns and trends with action plans written and implemented as needed. DNS/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months. The QAPI Committee will evaluate compliance with F-279**	

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	a bladder training program. During an interview on 4/7/15 at 8:15 a.m., the MDS Coordinator indicated the clinical record lacked a care plan for urinary incontinence. The MDS Coordinator indicated the toileting program would indicate the resident would be toileted upon rising, before and after each meal, at bedtime and prn (as needed). 3.1-35(a)			
F 312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. Based on observation, interview, and record review, the facility failed to provide ADL (activity of daily living) care to 2 of 3 residents who met the criteria in a total sample of 17 residents reviewed for ADL care, in that, 2 residents did not receive showers or oral	F 312	**F312 The corrective action for Resident #47. Oral care will be offered daily with personal care. All attempts at oral care will be documented on the oral care sheet & refusals will be documented on oral care sheet. All residents oral care needs will be assessed by oral**	05/07/2015

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	care. (Resident #13, Resident #47) Findings include: 1. During an observation on 3/30/15 at 3:10 p.m., Resident #13 was observed to be sitting in his room in a wheelchair. Resident #13 indicated he needed assistance for ADL (activity of daily living) care for his showers and teeth. Resident #13 indicated the staff helped him as necessary to clean his teeth usually once a month. The clinical record of Resident #13 was reviewed on 4/1/15 at 1:05 p.m. The clinical record indicated Resident #13 had diagnoses including, but not limited to, schizophrenia with acute exacerbation, insomnia,OCD (obsessive compulsive disorder), CHF (congestive heart failure), chronic bronchitis, hypothyroidism, and esophageal reflux. A quarterly MDS (Minimum Data Set) assessment, dated 2/12/15, indicated Resident #13 had a BIMS (Brief Interview for Mental Status) assessment score of 14, which indicated slight cognitive impairment. The MDS assessment further indicated Resident #13 was an extensive assistance of 1 person for personal hygiene which included oral care.		**health educator & appropriate supplies placed at bedside in sealed bag. All resident oral care needs will be documented on CNA care sheets by the DNS/designee in collaboration with the oral health educator. Any special oral care needs will be documented in the residents care plan. The care plan will be updated by the DNS/Designee by April 30, 2015. All nursing department staff will be in-serviced on the program and proper documentation by April 30, 2015 by DCE/designee. 20% of all residents will be questioned if oral care has been provided and oral checks completed on those unable to communicate by nursing administration 3 times per week for 2 weeks. Then 2 times per week for 2 weeks. Then weekly for 2 weeks. Then 10% will be audited 1 time per week for 2 weeks. Then 10% will be audited bi-weekly for 1 month then 10% will be audited one (1) time per month for three (3) months. An audit of the oral care sheets will also be completed two times a week for 1 month. Then 1 time a week for 2 months. Then bi monthly for 1 month. Then monthly for 2 months by DNS/designee to monitor compliance with the program.**	

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	The unit "100 Shower Schedule," obtained from LPN #2 on 4/1/15 at 8:30 a.m., indicated Resident #13 was to receive a shower every Wednesday and Saturday on the day shift. The ADL flow sheet, dated 1/31/15 - 3/31/15, indicated Resident #13 received a total of 7 (seven) showers on the following dates: 2/25/15, 2/28/15, 3/4/15, 3/13/15, 3/21/15, 3/25/15, and 3/28/15. Resident #13 should have received a total of 18 (eighteen) showers between 1/31/15 - 4/1/15. During an observation on 4/1/15 at 9:35 a.m., CNA #2 was observed to provide a shower to Resident #13. No oral care was provided. During an interview on 4/1/15 at 9:50 a.m., CNA #2 indicated oral care would be provided with the morning care and at bedtime. 2. During an observation on 3/31/15 at 9:31 a.m., Resident #47 was observed to be sitting in a wheelchair in the dining room. Resident #47 teeth were stained yellow with food particles present. During an interview on 3/31/15 at 9:36 a.m., Resident #47 indicated he would like to receive a shower everyday.		**The corrective action for resident #13. All residents will be offered preferences to shower/versus bath and time of day they wish to bath. The nursing staff will then initiate a shower schedule based on those preferences. This will be completed by 4/30/15. Showers will then be audited 3 times per week for 2 weeks. 2 times per week for 2 weeks. Weekly for 4 weeks and biweekly for 4 weeks then monthly for three (3) monts. The data will be analyzed for patterns and trends with action plans written and implemented as needed. DNS/Designee will review the results of the audits, trends, and action plans. The DNS/Designee will report findings at monthly QAPI meetings for six (6) months. The QAPI Committee will evaluate compliance with F-312**	

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	Resident #47 indicated he received usually 1 (one) shower a week. Resident #47 indicated he did not know what day the shower was supposed to be given, as it changed every week. During an observation on 4/1/15 at 10:20 a.m., Resident #47 was observed to be lying in bed. CNA #2 indicated she was going to provide a partial bath to Resident #47 as this was not a shower day for the resident. CNA #1 was observed to wash the resident 's periarea and change the brief. No further personal care was provided. During an interview on 4/1/15 at 1025 a.m., CNA #1 indicated if a resident does not receive a shower, pericare is given to the resident. The clinical record of Resident #47 was reviewed on 4/1/15 at 2:00 p.m. Resident #47 had a diagnoses including, but not limited to, dementia, mild intellectual disabilities, obstructive hydrocephalus, neurofibromatosis, hypertension, and irritable bowel syndrome. A quarterly MDS (Minimum Data Set) assessment, dated 1/16/15, indicated Resident #15 had a BIMS (Brief Interview for Mental Status) score of 4, which indicated severe cognitive impairment. The MDS assessment			

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	further indicated Resident #47 required extensive assistance of 1 person for personal hygiene. The unit "100 Shower Schedule", obtained from LPN #1 on 4/1/15 at 8:30 a.m., indicated Resident #47 was to receive a shower every Monday and Thursday on the evening shift. The ADL flow sheet, dated 1/31/15 - 4/1/15 and reviewed on 4/1/15 at 3:15 p.m., indicated Resident #47 received a total number of 12 (twelve) showers on the following dates: 2/2/15, 2/6/15, 2/11/15, 2/16/15, 2/20/15, 2/27/15, 3/2/15, 3/6/15, 3/13/15, 3/26/15, 3/27/15, and 3/30/15. The resident should have received a total number of 17 (seventeen) showers during the dates of 1/31/15 - 4/1/15. During an interview on 4/1/15 at 9:13 a.m., LPN #1 indicated residents usually receive a shower 2 times per week. LPN #1 further indicated if a resident wanted less or more showers, the staff would try to provide them. 3.1-38(a)(2)(A) 3.1-38(a)(3)(C)			

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	155390		04/07/2015

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F 329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. Based on observation, interview, and	F 329	**F329 The corrective action for Resident #37, #43, & #53.**	05/07/2015

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	record review, the facility failed to monitor psychoactive medication side effects for 3 of 5 residents reviewed for unnecessary medications. (Resident #37, Resident #43, Resident #53) Findings include: 1. On 4/1/15 at 8:39 a.m., Resident #37's clinical record was reviewed. Resident #37's diagnoses included, but were not limited to, delusional disorder, episodic mood disorder, unspecified psychosis, depressive disorder, and borderline personality disorder. The physician's recapitulation orders, signed 1/30/15, included, but was not limited to, Risperdal (an anti-psychotic medication) 0.5 mg (milligrams), give 0.5 mg, by mouth, one time a day. The Quarterly MDS (Minimum Data Set) Assessment, dated 3/6/15, indicated Resident #37 had received an anti-psychotic medication seven out of seven days during the assessment. The care plans included, but were not limited to: Potential for drug related complications associated with the use of psychotropic medications, dated 9/11/14. The interventions included, but were not limited to, monitor for side effects and		**Orders were added to MAR to observe resident for side effects related to psychoactive meds. All residents were assessed for use of psychoactive meds on 4-6-15. All residents found to be on psychoactive meds had orders entered to monitor for side effects of medication. All licensed nurses will be educated on the monitoring for side effects as per medication management policy by DNS/designee by 4/30/15. An audit of the medication administration record will be completed 1 time a week for 2 months, then bi weekly for 2 months, then monthly for 2 months and will be conducted by DNS/designee to monitor compliance with the care. The data will be analyzed for patterns and trends with action plans written and implemented as needed. DNS/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months. The QAPI Committee will evaluate compliance with F-329.**	

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	report to physician. The March 2015 MAR (Medication Administration Record) and TAR (Treatment Administration Record) lacked monitoring for side effects related to the use of the anti-psychotic medications. On 4/1/15 at 9:00 a.m., Resident #37 was observed in the hallway, in a wheelchair. Resident #37 indicated she was doing well that morning. On 4/1/15 at 10:13 a.m., LPN #3 was interviewed. LPN #3 indicated the side effects of psychoactive medications were monitored in the MAR. On 4/6/15 at 9:54 a.m., the DON (Director of Nursing) indicated they were unable to locate the monitoring of side effects for psychoactive medications for Resident #37. 2. On 04/01/15 9:00 a.m., Resident #43 was observed in bed drinking coffee. Resident #43 indicated he was doing well that morning. On 4/1/15 at 10:16 a.m., Resident #43's clinical record was reviewed. Resident #43's diagnoses included, but were not			

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	limited to, episodic mood disorder, insomnia, anxiety, panic disorder, depressive disorder, and schizoaffective disorder. The most recent signed physician's recapitulation orders, signed 1/30/15, included, but was not limited to: Buspar (an anti-anxiety medication) 15 mg (milligrams), give 15 mg, by mouth, four times a day. Prozac (an anti-depressant medication), give 40 mg, by mouth, every morning. Seroquel (an anti-psychotic medication), 200 mg, by mouth, three times a day. Trazodone (an anti-depressant medication), give 150 mg, at bedtime. Xanax (an anti-anxiety medication), give 1 mg, by mouth, four times a day. The Annual MDS (Minimum Data Set) Assessment, dated 2/6/15, indicated Resident #43 had received an anti-psychotic, anti-anxiety, and anti-depressant medication seven out of seven days during the assessment period. The care plans included, but were not limited to: Potential for drug related complications associated with the use of psychotropic medications, dated 3/26/13. The intervention included, but were not limited to, monitor for side effects and report to physician.			

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	The March 2015 MAR (Medication Administration Record) and TAR (Treatment Administration Record) lacked monitoring for side effects related to the use of the anti-psychotic, anti-anxiety, or anti-depressant medications. On 4/1/15 at 10:13 a.m., LPN #3 was interviewed. LPN #3 indicated the side effects of psychoactive medications were monitored in the MAR. On 4/6/15 at 9:54 a.m., the DON (Director of Nursing) indicated they were unable to locate the monitoring of side effects for psychoactive medications for Resident #43. 3. The clinical record of Resident #53 was reviewed on 04/01/15 at 2:18 p.m. The record indicated the diagnoses of Resident #53 included, but were not limited to schizoaffective disorder, anxiety disorder, and psychosis. The most recent Quarterly MDS (Minimum Data Set Assessment) dated 02/06/15 indicated Resident #53 experienced severe cognitive impairment.			

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	A Physician's order dated 01/09/15 indicated an order for Seroquel (anti-psychotic medication) 250 mg (milligram) by mouth at bedtime. A care plan was initiated on 08/10/13 for potential drug related complications associated with the use of psychotropic medications related to anti-psychotic medication. Interventions included, but were not limited to, monitoring and reporting side effects to the physician. The clinical record lacked any documentation for monitoring the side effects of an anti-psychotic medication found in the clinical record. An interview with the DON on 04/01/15 indicated that there was no documentation for monitoring the side effects of an anti-psychotic in Resident #53's clinical record. On 4/7/15 at 10:35 a.m., the DON provided the "Medication Management" policy, dated 5/12. The policy included, but was not limited to, the interdisciplinary team reviews the residents medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis.			

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	3.1-48(a)(3)			
F 371 SS=E Bldg. 00	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, interview, and record review, the facility failed to distribute food under sanitary conditions, for 4 (four) of 11(eleven) residents served in the 100 unit dining room, in that, coffee cups and drinking cups were handled by the rims and plates and bowls were handled by the edges. (Resident #4, Resident #1, Resident #6, Resident #13) 1. During an observation on 3/30/15 at 12:15 p.m., CNA #4 was observed to be delivering a lunch tray to Resident #4 in the 100 unit dining room. CNA #4 was observed to deliver the plate and dessert cup by the edges and picked up the coffee cup and juice cup by the rim. No hand	F 371	**F-371 The corrective action for Resident #4, Resident #1, Resident #6, and Resident #13. All staff will be educated on procedure related to hand hygiene and sanitation during meals and snack administration. This will be completed by 4.30.15 Staff will be audited 3 times per week for 2 weeks, then 2 times per week for 2 weeks, then weekly for 4 weeks, then bi-weekly for 4 weeks then monthly for three (3) months during meal/snack pass to observe for proper sanitation and hygiene procedures. The data will be analyzed for patterns and trends with action plans written and implemented as needed. DNS/Designee will review the**	05/07/2015

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	hygiene was observed prior to delivering the food. 2. During an observation on 3/30/15 at 12:16 p.m., CNA #1 was observed to be serving lunch to Resident #1. CNA #1 was observed to picked up the coffee and drinking cups with bare hands by the rims, touching the area where the resident's mouth would have touched. No hand washing was observed before or after serving the lunch to Resident #1. 3. During an observation on 3/30/15 at 12:18 p.m., CNA #1 was observed to remove the paper from around a drinking straw and place it into a drinking cup for Resident #6. No hand hygiene was observed. 4. During an observation on 3/30/15 at 12:20 p.m., CNA #1 was observed to deliver the lunch tray to Resident #13. CNA #1 was observed to obtain a coffee cup from a tray on a cart by the rim and nd fill it with coffee. CNA #1 then carried the coffee cup by the rim to Resident #13. No hand hygiene was observed. During an interview on 4/7/15 at 8:41 a.m., CNA #3 indicated plates and bowls should be carried from underneath and cups and glasses should be carried by the		**results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months. The QAPI Committee will evaluate compliance with F-371**	

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	handle or by the side. CNA #3 indicated plates, bowls, cups, and glasses should not be handled by the edges. 3.1-21(i)(3)			
F 441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin			

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment for 2 of 6 residents observed for care, in that, gloves were not changed and handwashing was not done for residents who received personal care. (Resident #13, Resident #47) 1. During an observation on 4/1/15 at 9:13 a.m., CNA # 2 was observed to be giving a shower to Resident #13. CNA #2 applied gloves prior to starting the shower. CNA #2 washed Resident #13's back, under the abdominal folds, periarea, and lower legs. CNA #2 dried the areas with a clean towel. CNA #2 applied the resident's clean brief, slacks,socks, shoes, and clean shirt. CNA #2 removed the gloves and obtained the resident's wheelchair. No glove change or hand hygiene was performed.	F 441	**F 441 Immediate corrective action: CNA #2 re-educated on proper hand washing technique and glove use on 04/02/2015. CNA#1 was re-educated on hand washing technique and glove use on 4/6/2015 All staff will be in-serviced on proper hand washing/hand sanitizing techniques with return demonstration by 4/30/15 by the DNS/designee. An audit of staff will be done on all units and all shifts three (3) times a week for one month. weekly for two (2) months, then bi weekly for one (1) month then monthly gor three (3) months. The data will be analyzed for patterns and trends with action plans written and implemented as needed. DNS/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months. The QAPI Committee will evaluate compliance with F**	05/07/2015

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	2. During an observation on 4/1/15 at 10:20 a.m., CNA #1 indicated Resident #47 was to receive a partial bath. CNA #1 applied gloves and lowered the resident's pants. CNA #1 removed the resident's brief, washed the perianal areas, placed a clean brief onto the resident and raised the resident's slacks. No glove change or hand sanitizing was observed. During an interview on 4/1/15 at 9:40 a.m., CNA #2 indicated if a resident did not receive a shower, the resident received a partial bath. CNA #1 indicated a partial bath included washing the resident's face, hands, axillas, and periarea. CNA #2 further indicated gloves should be changed and hands sanitized before and after providing care and if the gloves became soiled. A policy titled, "Handwashing/Hand Hygiene," revised August, 2014, and obtained from the DON (Director of Nursing) on 4/7/15 at 10:35 a.m., indicated staff should follow the handwashing/hand hygiene procedures to aid in the prevention and spread of infections to others. The policy indicated the use of gloves did not replace handwashing or hand hygiene.		**441**	

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	3.1-18(b) 3.1-18(l)			
F 465 SS=E Bldg. 00	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, interview and record review the facility failed to provide a safe functional, sanitary,and comfortable environment for residents, staff, and the public, in that, rooms had grout which was discolored, cove base peeling off, cracked laminate flooring, cracked caulking around a sink., entry door and closet doors with wood chipped on them. This included 9 of 23 rooms observed. The rooms are 105, 109, 111, 115, 206, 211, 215, 302, 306. Findings include: On 3/30/15, starting at 1:00 p.m. and on 3/31/15 from 8:00 a.m. to 2:00 p.m. during Stage 1 of resident observation, the following rooms were observed to have:	F 465	**F 465 Immediate corrective action: 1. Room 105 bed 1 and bed 2: The bathroom cove base and the entry door were repaired by maintenance. 2. Room 109 bed 1, bed 2 and bed 3. (referred to in the 2567 as bed 2, 3 and 4) Closet doors and entry door were repaired by maintenance. 3. Room 111 the caulking around the sink was repaired by maintenance. 4. Room 115 the caulking around the sink was repaired by maintenance. 5. The comb from between room 211 and 215 was removed from the bathroom. 6. The cove base in room 302 by the door was repaired by maintenance. 7. Room 306 The laminate in the bathroom was repaired by maintenance. Maintenance audited the remainder of the resident rooms to identify any similar issues identified by**	05/07/2015

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	1. Room 105-bed 1& bed 2- The cove base was cracked in the bathroom and the entry door had chipped wood. During a revisit on 4/6/15 the same was found.. 2. Room 109-bed 2 & bed 3 & bed 4 - The closet and entry doors was scuffed, entry door chipped. During a revisit on 4/6 /15 the same was found. 3. Rooms 111 & 115 - The caulking around sink was cracked. During a revisit on 4/6/15 the same was found. 4. Room 206-bed 1 - There was a odor in the bathroom and the grout behind commode was dirty. During a revisit on 4/6/15 there was no odor detected, but the grout behind the commode was dirty. 5. Room 211 & 215 - An unlabeled comb was in the shared bathroom. During a revisit on 4/6/15 the comb was still present and unlabeled. 6. Room 302-bed 1 - The cove base by door was detached. During a revisit on 4/6 /15 the same was found. 7. Room 306-bed 1 -The laminate in the bathroom was cracked. During a revisit on 4/6/15 the same was found.		**State Surveyors. Anything noted was repaired as necessary. Maintenance will do walkthroughs in a minimum of 10 resident rooms per week to observe the condition of resident rooms and identify any repairs needed. These walkthroughs will be documented on an audit sheet and retained in the executive director's office for six (6) months. The ED/designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months. The QAPI Committee will evaluate compliance with F 465**	

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	On 04/06/2015 at 2:54 p.m., an interview with Head of Environmental Services indicated that he thought all the rooms had been thoroughly cleaned. On 04/06/2015 2:58 p.m., an interview and touring with Head of Maintenance about the cove base, closet and entry doors with missing chips of wood. He indicated an initiative has been started by him to cover the ends of the door and fronts of doors with a protective covering. He also indicated the cove base will be fixed. On 4/6/15 at 9:00 a.m. a policy received from Head of Maintenance regarding general maintenance review and repair per month 3.1-19(f)			
F 514	483.75(l)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155390		04/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-WOODBRIDGE	816 N FIRST AVE EVANSVILLE, IN 47710

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SS=D Bldg. 00	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review, and interview, the facility failed to maintain accurate clinical records on 1 of 8 residents who received medications, in that, a resident received insulin but did not have a written physician's order for the dosage. (Resident #52) Findings include: During an observation on 3/30/15 at 10:55 a.m., LPN #1 was observed to be administering a Novolog insulin injection into the left deltoid region. LPN #1 indicated the resident's blood sugar was 256 mg/dl. The clinical record of Resident #52 was reviewed on 4/1/15 at 9:45 a.m. Resident #52 had a physician's order, dated	F 514	**F514 Corrective action for resident #52. Order entered for the medication that had been omitted. All licensed nurses will be re-educated on the policy for telephone orders by 4/30/2015. All telephone orders will be audited 3 times per week for 2 weeks, then 2 times per week for 2 weeks, then 1 time per week for 4 weeks and then 1 time bi-weekly for 4 weeks then monthly for three (3) months for completeness in the electronic medical records. The data will be analyzed for patterns and trends with action plans written and implemented as needed. DNS/Desigeee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months. The QAPI Committee**	05/07/2015

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	7/16/14, for Novolog insulin to be injected per sliding scale. The order indicated for a blood sugar of 256 mg/dl (milligrams/deciliter), Resident #52 was to receive 6 units of Novolog insulin. The clinical record lacked any documentation regarding a telephone order for insulin on 3/30/15. During an interview on 4/1/15 at 9:54 a.m., LPN #1 indicated on 3/30/15 Resident #52's blood sugar had been greater than 400 mg/dl. LPN #1 indicated she had notified Resident #52's physician and received an telephone order for Novolog insulin 15 units to be given at breakfast and lunch on that day. LPN #1 indicated the resident's blood sugar was to be rechecked later during the day. LPN #1 further indicated she thought she had written the telephone order and had documented the dose in the nurse's notes. A policy on physician telephone orders, effective 1/29/14 and obtained from the DON (Director of Nursing) on 4/7/15 at 10:35 a.m., indicated all physician's verbal and telephone orders would be documented. The policy further indicated the licensed nurse accepting the physician's order should include the date,		**will evaluate compliance with F514**	

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	time, physician's order, and name of the physician giving the order. 3.1-50(a)(1) 3.1-50(a)(2)			
F 999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to provide ongoing annual inservices for 3 of 10 employees reviewed, in that, annual Residents' Rights training was not completed. (DE #1, CNA #4, RN #2)	F 999	**F9999 Personnel files will be audited for all required annual in-services. Resident rights in-service was completed immediately for DE#1, CNA#4 and RN #2. All personnel will complete monthly in-services to meet annual requirements. Audits will be completed by Business Office Administrator (BOA)/designee monthly for six (6) months to assure compliance. The data will be analyzed for patterns and trends with action plans written and implemented as needed. BOA/designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for six (6) months. The QAPI Committee will evaluate compliance with**	05/07/2015

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	Findings include: On 4/6/15 at 2:00 p.m., the employee records were reviewed. DE (Dietary Employee) #1, CNA #4, and RN #2 lacked recorded annual Residents' Rights training. On 4/6/15 at 4:13 p.m., the Administrator and DON (Director of Nursing) indicated they were unable to access the annual Residents' Rights training for DE #1, CNA #4, and RN #2. On 4/7/15 at 10:35 a.m., the DON provided the 2015 Annual Education Calendar. The calendar indicated staff members were to receive Residents' Rights training in April 2015.		**F9999**	