

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  04/08/2014
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: 3/31/14, 4/1/14, 4/2/14, 4/3/14, 4/7/14, 4/8/14</p> <p>Facility Number: 000438 Provider Number: 155390 AIM Number: 100274170</p> <p>Survey Team: Barb Fowler RN TC Diane Hancock RN Denise Schwandner RN Diana Perry RN Anna Villain RN</p> <p>Census Bed Type: SNF/NF: 59 Total: 59</p> <p>Census Payor Type: Medicare:3 Medicaid: 52 Other: 4 Total :59</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on April 11, 2014 by Jodi Meyer, RN 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the</p>	F000000	<p><b>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 condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.</b></p>	
F000167 SS=B				

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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	<p>facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation, interview and record review, the facility failed to ensure survey results were available and accessible to residents, for 3 of 3 nursing units, in that the results were not present at all on two units and the most recent results available on the third unit were from 2012. (Units 100, 200, 300)</p> <p>Findings include:</p> <p>The Resident Council President was interviewed on 4/2/14 at 3:35 p.m. He indicated he thought there used to be a copy of the survey results in the lounge on the 100 Unit, which is located on the second floor of the facility. At 3:43 p.m., a sign was observed on a 100 Unit bulletin board that indicated a copy of the survey results could be found in the 100 Unit lounge. The 100 Unit lounge was observed at that time. There was no survey report observed in the room. The Activity Director was questioned and indicated there should be a copy in the lounge. She looked and was unable to find any reports. The 300 Unit lounge was observed at 3:50 p.m. There was a binder labeled State Survey Report, however, the most recent survey report was dated 2012. The 200 Unit lounge was observed at 4:00 p.m. and had no survey report. The three</p>	F000167	<p><b>F 167 Immediate corrective action: On 04/08/2014 Executive Director (ED) placed survey binders in the lounge area on units 100 and 200 with the latest updated survey information. The survey binder in the Dining Room on unit 300 was also updated with the latest survey. All staff will be educated on the location of the survey binders by 4/30/14 by the DCE/designee. Audits will be conducted by ED/designee daily for one (1) month then three (3) times a week for one month. Weekly for two (2) months. Then bi monthly for two (2) months. By verifying placement of survey binder on each unit and reviewing survey documents in each binder for the most recent survey report results. immediately. The audit data will be analyzed for missing binders or survey documents and will be corrected immediately as needed. ED/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI</b></p>	05/08/2014	

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F000225 SS=D	<p>units were observed to be on separate floors separated by steps. Elevators were available but were accessible using coded access that not all residents had access to.</p> <p>The Administrator was interviewed on 4/8/14 at 10:30 a.m. He indicated they had the most recent survey results in a book in the front lobby, but a code was required to get through the door from the nursing units. He indicated the 300 unit survey book was up to date as of the current date of 4/8/14. He indicated he would ensure the 100 and 200 Units had reports available.</p> <p>3.1-3(b)(1) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>		<p><b>meetings for three (3) months.</b> <b>The QAPI Committee will evaluate compliance with F 167</b></p>				

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	<p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that allegations of abuse were immediately reported to the administrator in 1 of 3 abuse allegations reviewed. (Resident #72, Resident #8)</p> <p>Findings include:</p> <p>On 4/2/14 at 10:00 a.m., Resident #72 was observed to kick towards Resident #8. Resident #8 yelled out indicating Resident #72 had kicked him.</p> <p>The "Progress Note" dated 4/2/14 at 10:14 a.m., indicated, "nurse at desk speaking with State worker, residents passing in front of desk going into dining room to attend activity: pt (patient) states 'hey dont (sic) hit me,' [patient] states 'hey, he raised his foot and it hit me on my elbow right here as I was going around him', entire arm inspected no, (sic) markings, bruises, swelling, or open areas noted, pt states 'I does not hurt anymore'.</p>	F000225	<p><b>F 225</b></p> <p><b>Immediate corrective action:</b> <b>Administrator notified at 10AM on 04/03/2014. Investigation initiated</b> <b>ISDH notified at 12:15 PM on 04/03/2014.</b></p> <p><b>All staff will be in serviced on immediate reporting of any allegation of Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of resident property by 4/30/14 by the DCE/designee.</b></p> <p><b>100% of reportable incidents will be monitored for time of incident and time of report to Executive Director/Administrator for one (1) month then 75% of incidents will be monitored for one (1) month then 50% will be monitored for two (2) months then 25% for two (2) months.</b></p>	05/08/2014

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F000226 SS=D	<p>Other resident removed from activities area, staff and nurse will monitor interactions between residents, will cont (continue) monitor."</p> <p>On 4/3/14 at 10:10 a.m., a list of resident's involved in allegations of abuse was provided by the DoN (Director of Nursing). Resident #72 and Resident #8 were not listed.</p> <p>On 4/3/14 at 1:45 p.m., the DoN indicated she was not aware of the incident between Resident #72 and Resident #8 until the morning of 4/3/14 during review of the nursing notes. On 4/8/14 at 2:00 p.m., the issue was reviewed with the Administrator and DoN. They indicated the administrator had not been notified of the incident.</p> <p>On 4/3/14 at 2:02 p.m., the "Protection from Abuse" policy, provided by the DoN, was reviewed. The policy indicated, "All allegations of abuse will be reported immediately to the administrator or their designated representative."</p> <p>3.1-28(c) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the abuse policy was followed, in that, allegations of abuse were not immediately reported to the administrator. (Resident #72, Resident #8)</p>	F000226	<p><b>ED/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months.</b></p> <p><b>The QAPI Committee will evaluate compliance with F225</b></p> <p><b>F 226</b> <b>Immediate corrective action:</b> <b>Administrator notified at 10AM on 04/03/2014. Investigation initiated</b> <b>ISDH notified at 12:15 PM on 04/03/2014.</b></p>	

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	<p>Findings include:</p> <p>On 4/2/14 at 10:00 a.m., Resident #72 was observed to kick towards Resident #8. Resident #8 yelled out indicating Resident #72 had kicked him.</p> <p>The "Progress Note" dated 4/2/14 at 10:14 a.m., indicated, "nurse at desk speaking with State worker, residents passing in front of desk going into dining room to attend activity: pt (patient) states 'hey dont (sic) hit me,' [patient] states 'hey, he raised his foot and it hit me on my elbow right here as I was going around him', entire arm inspected, no, (sic) markings, bruises, swelling, or open areas noted, pt states 'I does not hurt anymore'. Other resident removed from activites area, staff and nurse will monitor interactions between residents, will cont (continue) monitor."</p> <p>On 4/3/14 at 10:10 a.m., a list of resident's involved in allegations of abuse was provided by the DoN (Director of Nursing). Resident #72 and Resident #8 were not listed.</p> <p>On 4/3/14 at 1:45 p.m., the DoN indicated she was not aware of the incident between Resident #72 and Resident #8 until the morning of 4/3/14 during review of the nursing notes. On 4/8/14 at 2:00 p.m., the issue was reviewed with the Administrator and DoN. They indicated the administrator had not been notified of the incident.</p> <p>On 4/3/14 at 2:02 p.m., the "Protection from Abuse" policy, provided by the DoN, was reviewed. The policy indicated, "All allegations of abuse will be reported immediately to the administrator or their</p>		<p><b>All staff will be in serviced on immediate reporting of any allegation of Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of resident property by 4/30/14 by the DCE/designee.</b></p> <p><b>100% of reportable incidents will be monitored for time of incident and time of report to Executive Director/Administrator for one (1) month then 75% of incidents will be monitored for one (1) month then 50% will be monitored for two (2) months then 25% for two (2) months.</b></p> <p><b>ED/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months.</b></p> <p><b>The QAPI Committee will evaluate compliance with F226</b></p>				

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F000272 SS=D	<p>designated representative."</p> <p>3.1-28(a) 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.</p> <p>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.</p>	F000272	<b>F 272 For resident #42 MDS for Significant change 7/29/13 indicated that he was</b>	

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	<p>Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for incontinence, in the sample of 3 who met the criteria, and 1 of 3 reviewed for dental assessments in the sample of 7 who met the criteria, were comprehensively assessed on the Minimum Data Set Assessment for the issues. (Resident #42, #4)</p> <p>Findings include:</p> <p>1. Resident #42 was observed in bed in his room on 4/2/14 at 9:56 a.m. There was a urine odor in the room.</p> <p>Resident #42 was observed, on 4/7/14 at 9:00 a.m., to be transferred to bed by CNA #5. The resident was observed to be incontinent of a small amount of urine and a smear of bowel.</p> <p>Resident #42's clinical record was reviewed on 4/7/14 at 9:21 a.m. The resident was admitted to the facility 12/8/2008 with diagnoses including, but not limited to, aphasia, unspecified psychosis, chroiretinal scars, Down's syndrome, pervasive developmental disorder, constipation, dysthymic disorder, depressive disorder, encephalopathy, diabetes, hypothyroidism, and severe intellectual disabilities.</p> <p>Resident #42 had a significant change Minimum Data Set (MDS) assessment, dated 7/29/13. The MDS indicated the resident was nonverbal, had severely impaired cognitive skills for daily decision making, and unable to assess the resident's memory.</p> <p>The resident required extensive assistance of 1 person for dressing, eating, and hygiene.</p>		<p><b>incontinent on the MDS Quarterly dated 2/12/14 indicated that the resident was always continent. RNAC immediately corrected the MDS to show that the resident is mostly incontinent. Resident #4 was observed to have several missing teeth. MDS assessment on 10/3/13 indicated no dental issues. RNAC immediately corrected MDS. RNAC will be re-educated on RAI coding procedures by Clinical Assessment Reimbursement Coordinator by 5/5/2014. Clinical Assessment Reimbursement Specialist (CAR) will perform audits on 1 complete and 3 quarterly MDS assessments per month for 3 months then two (1) complete and two (2) quarterly MDS assessments for three (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) will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months. The QAPI Committee will evaluate compliance with F-272</b></p>		

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	<p>He was always incontinent of urine and bowel.</p> <p>The resident had a quarterly MDS assessment, dated 2/12/14, indicating total assistance for dressing and hygiene. Regarding bowel and bladder continence, the MDS indicated the resident was "always continent."</p> <p>Incontinence tracking from 2/7/14 through 2/12/14 indicated the resident was always incontinent.</p> <p>Interview with MDS coordinator on 4/8/14 at 9:15 a.m. indicated the resident was mostly incontinent and she would have to correct the MDS.</p> <p>2. During an observation on 4/2/14 at 8:48 a.m., Resident #4 was observed to be lying in bed. Resident #4 was observed to have several missing teeth.</p> <p>The clinical record for Resident #4 was reviewed on 4/3/14 at 9:15 a.m. Resident #4 had diagnoses including, but not limited to, hemiplegia, anemia, urinary tract infection, schizoaffective disorder, anxiety disorder, and post traumatic stress disorder. A significant change MDS (Minimum Data Set) assessment, dated 10/13/14, indicated Resident #4 had no dental issues.</p>			

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F000309 SS=D	<p>A dental consult form, dated 1/28/14, indicated Resident #4 was missing 7 (seven) maxillary teeth and 8 (eight) mandibular teeth.</p> <p>During an interview on 4/7/14 at 4:00 p.m., RN #1 indicated she was not aware the MDS for Resident #4's dental status was incorrect but she would correct it immediately.</p> <p>During an interview with the DoN (Director of Nursing) on 4/8/14 at 2:10 p.m., the DoN indicated the MDS had been corrected.</p> <p>3.1-31(c)(1) 3.1-31(c)(9) 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, interview, and record review, the facility failed to ensure 1 of 1 resident reviewed for dialysis had the fistula access site checked routinely for patency. (Resident #33)</p> <p>Finding includes:</p> <p>Resident #33 was observed on 4/3/14 at 8:41 a.m. to be up in a wheelchair in the dining/activity room. A dialysis access site was observed in her upper right arm; the site had a gauze dressing on it.</p>	F000309	<b>F309 The corrective action for Resident #33 an order to check access site daily for thrill/bruit daily was added to Treatment administration record (TAR) An audit was completed of all residents and at this time only Resident #33 is on dialysis. The access site check will be documented on the (TAR) All licensed nursing staff will be in serviced on the documentation/assessment of the access site by 4/30/14 by the DCE/designee. An audit</b>	

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	<p>Resident #33's clinical record was reviewed on 4/3/14 at 9:29 a.m. The resident was admitted to the facility on 12/6/14, readmitted on 2/26/14 and 3/20/14. Diagnoses included, but were not limited to, lower limb amputation, above knee, insomnia, anxiety state, constipation, depression, venous hypertension, pulmonary disease, thyroid disorder, chronic kidney disease, carcinoma of bladder, history of C. Difficile infection, anal fistula, dyspepsia, tobacco use disorder, diabetes type II, and end stage renal disease.</p> <p>The resident had a care plan for "Alteration in Kidney Function Due to End Stage Renal Disease (ESRD), related to risk for bleeding from access site, risk for infection related to fistula site." The care plan was dated 12/13/13. Interventions included, but were not limited to, the following: Check access site daily fistula/graft/catheter -signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, body chills) Dialysis center only to access catheter site Diet and fluid restrictions as ordered by physician... Do not take blood pressure, blood samples, or insert IV in arm with access site... Emergency protocol Labs Monitor for edema Monitor thrill and bruit daily and document Observe for signs and symptoms of bleeding.. Resident receives two meds from dialysis... Written communication form with review of weights and any changes in condition...</p> <p>LPN #1 was interviewed on 4/7/14 at 4:20 p.m. regarding Resident #33's dialysis</p>		<p><b>of the TAR will be completed time a week for 2 months. Then bi monthly for 1 month. Then monthly for 3 months will be conducted by DNS/designee to monitor compliance with the documentation. 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 three (3) months. The QAPI Committee will evaluate compliance with F-309</b></p>	

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F000312 SS=D	<p>treatments. She indicated they encouraged the resident to go to dialysis, because she refused at times. They encouraged her to follow her diet, because she didn't want to. Regarding the access site, she said she had a fistula in her right upper arm. She indicated they watched the site after dialysis, but they didn't do anything else; the resident was a 4 day per week dialysis resident. When asked specifically about checking for a thrill and bruit at the site, she indicated the resident used to have orders for that but she was back and forth from the hospital and the orders must have been left off. She said she had checked for the thrill and bruit, but not routinely and there wasn't anywhere to document it.</p> <p>The Director of Nurses provided a copy of the Dialysis Guideline, dated as revised 2013, at 2:46 p.m. on 4/8/14. The procedure included, but was not limited to, the following: "Check fistula for bruit (listening to fistula) or feel for a thrill (by touching the fistula). This must be done daily, best after dressing is removed." "If you do not feel a pulse or hear a bruit, check again by placing your fingers gently over fistula and check for a thrill. Call the dialysis unit immediately. If the unit is closed, call the M.D." "Documentation on Treatment Sheets includes: -Fistula checks daily: Monitoring for presence of bruit and thrill..."</p> <p>3.1-37(a) 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the</p>			

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	<p>necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interview, the facility failed to provide adequate oral hygiene to 2 of 3 residents, in that, no oral care was provided to the residents. (Resident #40, Resident #4)</p> <p>Finidngs include:</p> <p>1. During an observation on 4/3/14 at 8:48 a.m., Resident #4 was observed to be lying in bed. Resident #4 was observed to have several missing teeth. Resident #4 indicated the facility staff did not provide oral care to the residents most of the time.</p> <p>During an observation on 4/7/14 at 11:25 a.m., CNA #1 was observed to be giving a.m. care to Resident #4. No oral care was offered or provided before, during, or after the a.m. care.</p> <p>The clinical record of Resident #4 was reviewed on 4/3/14 at 9:15 a.m. Resident #4 had diagnoses including, but not limited to, hemiplegia, anemia, urinary tract infection, left side weakness, schizoaffective disorder, and post traumatic stress disorder.</p> <p>A care plan, initiated 3/10/10, indicated Resident #4 had a physical functioning deficit related to self care impairment. The care plan indicated Resident #4 was to receive oral care assistance. A MDS (Minimum Data Set) assessment, dated 1/17/14, indicated Resident #4 had slight cognitive impairment and was an extensive assist of 1 (one)</p>	F000312	<p><b>F312</b></p> <p><b>The corrective action for Resident #4 &amp; 40. Oral care will be offered daily with personal care. All attempts at oral care will be documented on the oral care sheet &amp; refusals will be documented on oral care sheet.</b></p> <p><b>All residents oral care needs will be assessed by oral health educator &amp; appropriate supplies placed at bedside in sealed bag.</b></p> <p><b>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, 2014.</b></p> <p><b>All nursing department staff will be in-serviced on the program and proper documentation by April 30, 2014 by the oral health educator/DCE/designee.</b></p> <p><b>An audit of the oral care sheets will 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 monthly by oral health educator/designee to monitor compliance with the program.</b></p>	05/08/2014			

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	<p>person for personal hygiene.</p> <p>2. During an observation on 4/3/14 at 8:40, Resident #40 was observed to be lying in bed with food debris on her teeth.</p> <p>During an observation on 4/7/14 at 10:10 a.m., Resident #40 was observed to have food debris on her teeth.</p> <p>During an observation on 4/7/14 at 10:23 a.m., CNA #1 was observed to be giving a.m. care to Resident #40. CNA #1 did not provide or offer oral care to Resident #40 before, during, or after the a.m. care. Upon completion of a.m. care, CNA #1 was observed to wheel Resident #40 to the dining room where Resident #40 was given a milkshake to drink.</p> <p>The clinical record of Resident #40 was reviewed on 4/3/14 at 8:55 a.m. Resident #40 had diagnoses, including but not limited to, Alzheimer's disease, depressive disorder, anxiety disorder, and failure to thrive. An annual MDS (Minimum Data Set) assessment, dated 2/22/14, indicated Resident #40 was total dependent of 1 (one) person for personal hygiene.</p> <p>During an interview on 4/8/14 at 7:35 a.m., CNA #2 indicated oral care was to be provided daily. CNA #2 indicated oral care would usually be done when the resident is given a.m. care or upon arising from bed.</p> <p>A procedure titled, "Oral Hygiene," dated 2006 and obtained from the DoN (Director of Nursing) on 4/7/14 at 4:39 p.m., indicated the purpose of oral hygiene was to cleanse the mouth, teeth, and dentures, to prevent infection and irritation, to moisten the mucous</p>		<p><b>The data will be analyzed for patterns and trends with action plans written and implemented as needed.</b></p> <p><b>DNS/Designee will review the results of the audits, trends, and action plans. The oral health educator will report findings at monthly QAPI meetings for three (3) months.</b></p> <p><b>The QAPI Committee will evaluate compliance with F-312</b></p>	

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F000315 SS=D	<p>membranes, and to promote personal hygiene.</p> <p>3.1-38(a)(3)(C) 3.1-38(b)(1) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to provide catheter care to 1 of 7 residents reviewed with urinary catheters, in that catheter care was not provided to a resident with a catheter. (Resident #4)</p> <p>Findings include:</p> <p>During an observation on 4/2/14 at 10:02 a.m., Resident #4 was observed to have an indwelling foley catheter draining to gravity. Resident #4 indicated she currently had an urinary tract infection and was receiving 2 (two) antibiotics.</p> <p>During an observation on 4/7/14 at 11:25 a.m., CNA #1 was observed to be giving a bath to Resident #4. CNA #1 provided no catheter care to Resident #4.</p>	F000315	<p><b>F315</b> <b>The corrective action for Resident #4. Foley catheter care will be provided every shift. All residents were assessed for Foley/supra-pubic catheter on 4/8/14.</b></p> <p><b>All resident charts were audited for catheter care orders. All residents requiring catheter care will have individualized care plans to reflect the need for catheter care by 4/21/14. All CNA care sheets will be updated to reflect need for catheter care by 4/21/14 by the DNS/designee.</b></p> <p><b>All CNA's will be educated on proper catheter care/technique with hands on return demonstration by the</b></p>	

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F000318 SS=D	<p>The clinical record of Resident #4 was reviewed on 4/3/14 at 9:15 a.m. Resident #4 had diagnoses including, but not limited to, hemiplegia, anemia, urinary tract infection, urinary incontinence, schizoaffective disorder, and post traumatic stress disorder. A MDS (Minimum Data Set), dated 1/17/14, indicated Resident #4 had no cognitive impairment. The MDS further indicated the resident had an indwelling foley catheter.</p> <p>A physician's order, dated 12/9/13, indicated Resident #4 was to receive catheter care every shift.</p> <p>During an interview on 4/8/14 at 7:35 a.m., CNA #2 indicated a resident with a foley catheter should be given catheter care every shift and after each incontinence. CNA #2 further indicated the residents are to be observed for incontinence every 2 (two) hours.</p> <p>During an interview on 4/8/14 at 10:23 a.m., the DoN (Director of Nursing) indicated Resident #4 was to have catheter care provided every shift. The DoN indicated the facility staff would be educated on catheter care immediately.</p> <p>A procedure, titled "Catheter Care, Indwelling Catheter" and dated 2006, indicated the procedure for catheter care included pouring warm water over the perineum, washing the perineum well with soap and water, removing debris from the catheter at the insertion site, and rinsing well with warm water.</p> <p>3.1-41(a)(2) 483.25(e)(2) INCREASE/PREVENT DECREASE IN</p>		<p><b>DCE/designee by 4/30/14.</b></p> <p><b>An audit of the treatment administration record will be completed 1 time a week for 2 months. Then bi monthly for 2 month. Then monthly for 2 months will be conducted by DNS/designee to monitor compliance with the care.</b></p> <p><b>The data will be analyzed for patterns and trends with action plans written and implemented as needed.</b></p> <p><b>DNS/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months.</b></p> <p><b>The QAPI Committee will evaluate compliance with F-315.</b></p>				

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	<p><b>RANGE OF MOTION</b> Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview, and record review, the facility failed to provide services to 1 of 5 residents reviewed, in that, a resident with a contracture did not receive ROM (range of motion) to the affected area. (Resident #4)</p> <p>Findings include:</p> <p>During an observation on 4/2/14 at 11:45 a.m., Resident #4 was observed to have a contracture of the left hand. Upon observation, Resident #4 was observed with no splint or brace in use. Resident #4 indicated she received no range of motion to the area.</p> <p>The clinical record of Resident #4 was reviewed on 4/3/14 at 9:15 a.m. Resident #4 had diagnoses including, but not limited to, hemiplegia, anemia, urinary tract infection, schizoaffective disorder, and post traumatic stress disorder. A MDS (Minimum Data Set) assessment, dated 1/17/14, indicated Resident #4 had no cognitive impairment. The MDS further indicated Resident #4 received ROM.</p> <p>A care plan, initiated 3/10/10, indicated Resident #4 had a physical functioning impairment related to ROM limitations. The care plan further indicated Resident #4 received a restorative program.</p>	F000318	<p><b>F-318</b> The corrective action for Resident #4. The FMP was documented in the care plan and added to the CNA care sheet. restorative program/FMP by the RNAC/designee by 4/21/2014.</p> <p>All residents were assessed for contractures between 4/18/14 and 4/25/14 by RNAC/designee</p> <p>All resident charts were audited for orders for ROM and/or splints or positioning devices between 4/18/14 and 4/25/14 by RNAC/designee.</p> <p>All residents with need for ROM, splints and positioning devices will be documented on the restorative record/FMP and all resident care plans will be individualized and updated to reflect these needs by 4/30/14 by RNAC/designee.</p> <p>The splints, positioning devices and ROM program will be documented on the restorative record/FMP and all nursing department staff will be in-serviced by the RNAC/Designee on the program and proper documentation by 4/30/2014.</p>	05/08/2014

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F000329 SS=D	<p>During an interview on 4/3/14 at 10:56 a.m., CNA #4 indicated she assisted with the restorative program. CNA #4 indicated Resident #4 no longer received the restorative nursing program. She indicated the CNAs provided ROM to the resident.</p> <p>During an interview on 4/8/14 at 9:27 a.m., CNA #1 indicated Resident #4 did not use a splint to her left hand. CNA #1 indicated Resident #4 used a squeeze ball to work the left hand at times. CNA #1 indicated he provided the squeeze ball to Resident #4 whenever he remembered.</p> <p>During an interview on 4/8/14 at 10:21 a.m., the DoN (Director of Nursing) indicated Resident #4 received restorative nursing.</p> <p>During an interview on 4/8/14 at 11:16 a.m., RN #1 indicated Resident #4 received ROM as part of the functional maintenance program.</p> <p>A procedure, titled "Range of Motion Exercises," dated 2006 and obtained from the DoN on 4/7/14 at 4:27 p.m., indicated ROM should be provided to prevent contractures.</p> <p>3.1-42(a)(2) 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</p>		<p><b>An audit of the restorative record/FMP will 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 will be conducted by RNAC/designee to monitor compliance with the program.</b></p> <p><b>The data will be analyzed for patterns and trends with action plans written and implemented as needed.</b></p> <p><b>RNAC/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months.</b></p> <p><b>The QAPI Committee will evaluate compliance with F-318</b></p>	
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	<p>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 2 of 5 residents reviewed for unnecessary medications was free of unnecessary medications, in that an anti-psychotic medication was administered without a diagnosis that supported it's use and that the facility failed to monitor pain levels for the use of pain medication, (Residents #72 and #33)</p> <p>Findings include:</p> <p>1, The clinical record of Resident #72 was reviewed on 4/3/14 at 8:38 a.m. The record indicated the diagnoses of Resident #72 included, but was not limited to, quadriplegia and quadriparesis C1-C4 incomplete, cystostomy, neurogenic bladder, dysphagia, gastrostomy, Down's syndrome, anxiety disorder, Alzheimers disease, hyperlipidemia, spinal stenosis in cervical region, spinal cord injury, and rhinitis.</p>	F000329	<p><b>F329</b></p> <p><b>Corrective action for Resident #72. MD notified of need for clarification of diagnosis. Diagnosis added to medical record for medication on 4/9/14.</b></p> <p><b>All residents charts will audited for anti-psychotic use by consultant pharmacist and appropriate recommendations made to MD for diagnosis by 4/30/14.</b></p> <p><b>A daily audit of addition anti-psychotics to patient regimes on current residents will be completed by the DNS/designee. Documentation for appropriate diagnosis will be monitored. The consultant pharmacist will be notified of any anti-psychotics without proper diagnosis.</b></p> <p><b>Corrective action for Resident #33.</b></p>	05/08/2014

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	<p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 1/10/14 indicated Resident #72 had a BIMS score (Brief Interview for Mental Status) of 0 of 15 which indicates severe cognitive impairment.</p> <p>The physician's orders indicated Resident #72 was receiving Risperdal (an anti-psychotic) 1.5 mg (milligram) by mouth at bedtime related to Down's syndrome, anxiety disorder conditions classified elsewhere, and Alzheimers disease. No diagnosis was documented for anti-psychotic medication use.</p> <p>An interview with the DoN (Director of Nursing) on 4/8/14 at 10:28 a.m., indicated that none of the three diagnoses for anti-psychotic medications were among the resident's diagnosis list. She also indicated that she would look for more information.</p> <p>An interview with DoN on 4/8/14 at 11:09 a.m., indicated that she had spoken with the physician's office and that the resident is on Risperdal for aggressive behaviors. The office is sending documentation for the diagnosis.</p> <p>The DoN presented a faxed physician's order for a Risperdal diagnosis for aggressive behavior secondary to Downs syndrome dated 4/8/14.</p> <p>2. Resident #33's clinical record was reviewed on 4/3/14 at 9:29 a.m. The resident was admitted to the facility on 12/6/13, readmitted on 2/26/14 and 3/20/14. Diagnoses included, but were not limited to, lower limb amputation, above knee,</p>		<p><b>Resident in hospital for unrelated issue at this time. Will address pain issues upon return to facility.</b></p> <p><b>All Licensed nurse staff will be in-serviced on proper documentation according to the "pain management guideline" with particular attention to documentation of non-pharmaceutical interventions prior to prn medication administration, pain scale use and prn follow-up documentation by 4/30/14 by the DCE/designee.</b></p> <p><b>Audits will be conducted by DNS/designee three (3) times a week for one month. Weekly for two (2) months. Then bi monthly for two (2) months. Then monthly for one month. By reading the progress notes for accurate and complete documentation related to prn medications. Licensed nurses who are not following the "pain management guideline" will be re-educated immediately.</b></p> <p><b>The data will be analyzed for patterns and trends with action plans written and implemented as needed.</b></p> <p><b>DNS/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months.</b></p> <p><b>The QAPI Committee</b></p>	

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	<p>insomnia, anxiety state, constipation, depression, venous hypertension, pulmonary disease, thyroid disorder, chronic kidney disease, carcinoma of bladder, history of Clostridium Difficile infection, anal fistula, dyspepsia, tobacco use disorder, diabetes type II, and end stage renal disease. The resident had current physician's orders for Oxycodone HCL (hydrochloride) (pain medication) 5 milligrams per milliliter (ml) give 5 ml by mouth every 4 hours as needed for pain.</p> <p>Resident #33 had a care plan, dated 12/7/13, regarding the need for pain management and monitoring related to phantom pain. Interventions included, but were not limited to, "Evaluate and establish level of pain on numeric scale/evaluation tool."</p> <p>Review of the Medication Administration Record (MAR) for April, 2014, indicated the resident had been given Oxycodone HCL 5 mg/ml, 5 ml by mouth on 4/6/14 at 6:45 p.m. and 4/7/14 at 2:05 a.m. The MAR lacked any documentation of the level of pain prior to the administration of the medication or the reason for the medication.</p> <p>Review of progress notes indicated the following: 4/6/14 1845 (6:45 p.m.) "Oxycodone HCL solution 5 mg/5ml give 5 ml by mouth every 4 hours as needed for pain." 4/7/14 0205 (2:05 a.m.) "Oxycodone HCL solution 5 mg/5 ml give 5 ml by mouth every 4 hours as needed for pain - given per request for c/o [complaint of] leg et back pain - not relieved by rest or repositioning."</p> <p>There was no indication the severity of the pain was assessed prior to the administration</p>		<b>will evaluate compliance with F-329</b>	

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F000441 SS=D	<p>of the medication on either date the medication was given. On 4/6/14, the documentation did not include the location of the pain.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 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 - (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>			

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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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	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper handwashing procedures were performed for 2 of 3 resident observed receiving personal hygiene. (Resident #4, Resident #40)</p> <p>Findings include:</p> <p>1. During an observation on 4/7/14 at 10:23 a.m., Resident #4 was observed to be receiving a bed bath. During the bed bath, Resident #4 was incontinent of urine. CNA #1 was observed to change gloves with no evidence of handwashing observed.</p> <p>2. During an observation on 4/7/14 at 11:25 a.m., Resident #40 was observed to be receiving a bed bath. CNA #1 sanitized his hands and apply gloves prior to the start of the bath. CNA #1 was observed to change his gloves during the bath but did not perform hand hygiene.</p> <p>During an interview on 4/8/14 at 7:35 a.m., CNA #2 indicated hands should be washed and gloves applied prior to starting resident's care and gloves should be changed, hands washed after leaving a dirty area and going to a clean area on the resident, and at the end of the resident's care.</p> <p>A procedure, titled, "Hand Washing," dated 2006 and obtained from the DoN (Director of Nursing) on 4/7/14 at 4:39 p.m., indicated hands should be washed before and after</p>	F000441	<p><b>F 441</b></p> <p><b>Immediate corrective action:</b> <b>CNA #1 re-educated on proper hand washing technique on 04/08/2014.</b></p> <p><b>All staff will be in-serviced on proper hand washing/hand sanitizing techniques with return demonstration by 4/30/14 by the DCE/designee.</b></p> <p><b>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 monthly for two (2) months. Then monthly for one (1) month.</b></p> <p><b>The data will be analyzed for patterns and trends with action plans written and implemented as needed.</b></p> <p><b>DNS/Designee will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months.</b></p> <p><b>The QAPI Committee will evaluate compliance with F 441</b></p>	05/08/2014	

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F000460 SS=D	<p>resident contact and when soiled.</p> <p>3.1-18(1) 483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>Based on observation and interview, the facility failed to ensure privacy curtains were provided and/or were long and/or wide enough to provide privacy in 3 of 22 rooms. (Rooms 103, 106, and 310) This had the potential to affect 6 residents who resided in the rooms.</p> <p>Findings include:</p> <p>1. Room 103 was observed on 4/2/14 at 8:58 a.m. The privacy curtains for bed 1 and bed 3 were short, so that each resident's bed could be seen under the curtain. Three residents resided in the room.</p> <p>Room 103 was observed again on 4/8/14 at 10:20 a.m. Bed 1's curtain was still too short.</p> <p>2. Room 106 was observed on 4/2/14 at 9:03 a.m. The room was a private room with one resident. The room had a bathroom in it that had no door or privacy curtain, allowing the bathroom area to be viewed from the main door when it was opened.</p>	F000460	<p><b>F460 Immediate corrective action: Rooms 103, 106, 310 correct length and width privacy curtains were hung 04/08/2014. On 04/16/2014 the ESM conducted a house wide audit on all privacy and window curtains to assure proper length and width for sufficient privacy. All Laundry staff will be re-educated on the checking privacy curtains for proper length and width to ensure privacy 04/17/2014. Audits will be conducted by Environmental Services Manager (ESM) to verify proper length and width curtains five (5) times a week for one month. (3) times a week for one month. Weekly for two (2) months. Then bi monthly for two (2) months. The data will be analyzed for patterns and trends with action plans</b></p>	

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F000465 SS=E	<p>The room was observed again on 4/8/14 at 10:20 a.m. and remained the same.</p> <p>3. Room 310 was observed on 4/2/14 at 3:29 p.m. The privacy curtain was not wide enough to ensure privacy for both residents in the room. This remained the same when observed again on 4/8/14 at 10:20 a.m.</p> <p>3.1-19(k) 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.</p> <p>Based on observation and interview, the facility failed to ensure a safe, functional, sanitary and comfortable environment for 6 of 22 resident rooms observed, in that floors were soiled, soiled and/or unlabeled items were observed in the bathrooms, and an overbed table was missing. (Rooms 108, 107, 115, 203, 215, 116) Two (2) of 17 residents interviewed during stage 1 interviews indicated the facility was not clean. (Residents #85 and #86)</p> <p>Findings include:</p> <p>1. Room 108 was observed on 4/2/14 at 9:23 a.m. The bathroom floor had a large area of wax/dirt build-up. There was a soiled/stained plastic drinking cup full of water setting on the sink. There was a tube of ketoconazole cream (antifungal) in a soiled labeled plastic bag setting on the back of the sink. There was an uncovered, unlabeled toothbrush on a shelf over the sink. There</p>	F000465	<p><b>written and implemented as needed. ESM will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months. The QAPI Committee will evaluate compliance with F 460</b></p> <p><b>F 465</b> <b>Immediate corrective action:</b> <b>On 004/08/2014 Rooms 108, 107, 115, 116, 203, 215 were cleaned completely.</b></p> <p><b>On 04/09/2014 the ESM conducted a house wide audit for housekeeping compliance. All areas of concern were cleaned to guarantee compliance.</b></p> <p><b>All Housekeeping staff will be re-educated on the 10 step cleaning process on 04/17/2014.</b></p> <p><b>Audits will be conducted by Environmental Services Manager (ESM) five (5) times a week for one month. Three (3) times a week for one month. Weekly for two (2) months. Then bi monthly for two (2) months.</b></p> <p><b>The data will be analyzed for</b></p>				

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	<p>was a hairbrush setting on the back of the sink with no name. This area was the same when observed again on 4/8/14 at 10:20 a.m.</p> <p>2. Room 107 was observed on 4/2/14 at 9:39 a.m. There was no overbed table for the resident in bed 2. There was a paper leaflet laying on the floor near the head of bed 2. The room was observed again at 11:40 a.m. after the housekeeper had been in the room. The paper leaflet was still on the floor in the same location.</p> <p>3. Room 115 was observed on 4/2/14 at 8:56 a.m. The edges and corners of the floor were soiled with a build-up of wax and dirt. The bathroom floor was soiled/stained, especially the edges and threshold of the door. The floor was the same on 4/8/14 at 10:20 a.m.</p> <p>4. Room 203 was observed on 4/2/14 at 9:54 a.m. The edges and corners of the floor in the room and the threshold of the door had a build-up of soil/stain. There was a urine odor in the room. The room was the same when observed on 4/8/14 at 10:20 a.m.</p> <p>5. Room 215 was observed on 4/2/14 at 10:09 a.m. The bathroom floor were soiled in the corners and edges at the baseboard.</p> <p>6. Room 116 was observed on 4/2/14 at 8:33 a.m. The corners and edges of the floor and the threshold of the door were soiled with a gray build-up and dirt. This was the same on 4/8/14 at 10:20 a.m.</p> <p>7. Two residents were confidentially interviewed on 4/2/14 at 8:29 a.m. and 8:57 a.m., Residents #85 and #86, and indicated the building was not clean. One indicated</p>		<p><b>patterns and trends with action plans written and implemented as needed.</b></p> <p><b>ESM will review the results of the audits, trends, and action plans and report findings at monthly QAPI meetings for three (3) months.</b></p> <p><b>The QAPI Committee will evaluate compliance with F 465</b></p>				

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	<p>simply, "no" when asked if the building was clean. The other resident indicated the bathroom was a mess at times.</p> <p>3.1-19(f)</p>			