

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: May 28, 29, 30, 31, and June 3, 4, 2013.</p> <p>Facility number: 000033 Provider number: 155375 Aim Number: 100266280</p> <p>Survey team: Terri Walters RN TC Martha Saull RN Dorothy Watts 5/28/13, 5/29/13, 6/3/13, 6/4/13 Carole McDaniel 5/28/13, 5/29/13, 5/30/13</p> <p>Census bed type: SNF/NF: 56 Total: 56</p> <p>Census payor type: Medicare: 4 Medicaid: 43 Other: 9 Total: 56</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review was completed on June 11, 2013, by Jodi Meyer, RN</p>	F000000		
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(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			
F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure residents were provided with adequate eating utensils during meals for 2 of 3 meals observed on the Alzheimers Unit, with the potential to affect all 30 residents. Resident 67, 17, 18, 41, 2</p> <p>Findings include:</p> <p>On 5/28/13 during the noon meal observation on the Alzheimers Unit, the residents were observed eating turkey divan. The entree included slices of turkey in a cream sauce with broccoli. None of the residents were observed to have butter knives. During the meal observation, residents were observed trying to eat larger than bite sized portions and/or pick up the meat with their fingers and/or select the turkey out of the entree and leave it uneaten and/or drop it on themselves. Three residents at one table, who were seated together, began to discuss their difficulties. Resident #2 stated "well here" and demonstrated trying to</p>	F000241	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Staff to set table with appropriate silverware.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All 22 residents, not 30 per observation have the potential to be affected by this deficient practice. All resident on Alzheimer's unit will have full set of eating utensils at each meal unless otherwise noted by physician order and care plan. Staff will assist with meal prep while maintaining the residents highest level of independence while maintaining their dignity.</p> <p>What measures will be put into place or what systemic changes</p>	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>use a spoon unsuccessfully to cut the meat. Resident #41 stated "are these things swimming from you too?" The staff in the dining room at that time, did not cut the meat for the residents and/or provide them with butter knives. A third resident, Resident #67, who was nonverbal, but was trying to mimic with a fork to cut the meat, as staff had demonstrated to other residents. Staff did not offer the use of a knife to the residents.</p> <p>On 5/29/3 at 11:30 A.M. the Alzheimers dining room was observed during the noon meal. The meal being observed served included, but was not limited to, the following: a piece of breaded fish, a slice of bread and packets of butter were placed on the resident's plates. At that time, the residents place settings at the table included a fork and spoon. No knife was provided at the table. At that time, CNA (certified nursing assistant) #3 and CNA #4 were observed passing out food filled plates to the residents.</p> <p>At that time, Resident #18 was observed to be spreading butter on her fish with her fingers. Resident #17 was observed to spread mayonnaise on her bread with her fork. Resident #67 was observed to</p>		<p>will be made to ensure that the deficient practice does not recur:</p> <p>New Alzheimer's Care Director or designee will monitor meal periods for proper utensil set up and residents are assisted as needed to maintain their highest functional individual independence while maintaining their dignity.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>ACU Director or designee will monitor meal periods 5 times weekly for 4 weeks, then 3 times weekly for 3 weeks, then 2 times weekly 3 weeks the quarterly as needed. This will be monitored and discussed during monthly QAPI meeting.</p> <p>Date the systemic changes will be completed: 7/3/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>spread butter on her bread with a spoon. Staff did not offer the use of a knife to the residents.</p> <p>On 5/30/13 at 12:20 P.M., the RD (Registered Dietician) and DON (Director of Nursing) were interviewed. The DON indicated prior to her position as the DON, she was the Alzheimers Unit Director. She indicated she didn't know why the residents were not given butter knives but stated "when I came they were not provided knives so I continued that. I guess it's a mind set."</p> <p>3.1-3(t)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(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	
F000253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview and record review, the facility failed to maintain resident bathrooms and bedrooms free of pervasive urine odors for 2 of 16 resident room/bathrooms. Room 202, Room 111</p> <p>Findings include:</p> <p>1. On 5/28/13 at 11:50 A.M., both residents in Room 202 were observed in the room. At that time, the bathroom has observed and had a very strong, foul, urine odor detected. The odor was also detected the bedroom portion of Room #202. Resident # 40 was observed at that time, walking to the bathroom. Resident #40's bed was unmade. A dried urine ring was observed on the residents bed sheet at least a foot in diameter on the bottom sheet of the residents bed.</p> <p>On 5/28/13 at 11:50 P.M., the bathroom in room #202, which was shared by 2 residents, had a strong urine odor. A dark ring stained the floor located at the base of the</p>	F000253	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>CNA assignment sheet updated to reflect check of proper hygiene and cleanliness of self and patient room. Resident #40 will be screened for possible UI program through therapy department. Mattress was removed from room and replaced. Bathroom and room was deep cleaned immediately along with resident's personal chair. Resident #55 bathroom flooring stripped and waxed..</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All resident rooms have the potential to be affected. Audit of resident bathrooms and mattresses will be assessed for corrective action, i.e. replacement or deep cleaning on a monthly basis.</p>	07/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>commode.</p> <p>At 11:55 A.M., CNA #2 removed the soiled bottom sheet. At that time, the bare mattress was observed. On the area of the mattress where the residents buttocks would be positioned on the bed, the blue vinyl covering was missing exposing the tan fabric beneath. The area was observed to be at least a foot in diameter. The area of exposed tan fabric was located on the bed where the dried urine stain was observed on the bottom sheet. At the time, a very strong urine odor was detected in the resident's room.</p> <p>On 5/29/13 at 10:26 A.M., Resident #40 was observed in his room in bed. Again, the very strong, pervasive urine odor persisted in the room.</p> <p>On 5/30/13 at 11:12 A.M., the resident was not in Room 202. The resident's bed was unmade and the sheets were observed to be dry, but the strong, pervasive old urine odor persisted.</p> <p>On 5/31/13 at 10:35 A.M. Physical Therapy (PT) staff was observed going into Room 202 to assist Resident #40. When PT Staff #1 and</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>On the monthly Deep Cleaning Calendar, housekeeping staff will check mattress for any possible defects that may cause issues with odor (Addendum:and report to DNS or designee for replacement of mattress. Also on daily housekeeping check sheet they will mark high risk room (Addendum: with tendencies for odors to be checked again throughout day for any additional cleaning. Staff inserviced on cleaning calendar and housekeeping check sheet for additional duties.)</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Each room is deep cleaned per monthly schedule and cleaned daily. High risk rooms will be monitored daily and cleaned more than once a day if indicated. Audits will be reviewed during our monthly QAPI meeting (Addendum: times 4 months then quarterly times 3 then as necessary).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Resident #40 left the room, the strong urine odor persisted.</p> <p>On 5/31/13 at 2 P.M., a strong pervasive old urine odor was detected in the hall outside of Room 202.</p> <p>On 5/30/13 at 9:20 A.M. the current CNA (certified nursing assistant) assignment sheet was received from LPN #2. The form indicated the resident was incontinent of bowel and bladder at times and should be checked for soiling. The form also noted the resident needed moderate assist with care, observe for soiling of clothes and offer assistance as needed with changing.</p> <p>On 5/31/13 at 10 A.M. the clinical record of Resident #40 was reviewed. The MDS (minimum data set assessment) dated 3/2/13 indicated the resident was of independent cognition; no toileting plan and resident is always continent of bowel and bladder.</p> <p>On 6/3/13 at 12:10 P.M., the Administrator (ADM) was taken to Room 202. She indicated at that time, she was aware of the pervasive old, urine odor. At that time, she was also made aware of the condition of the mattress with the missing blue,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>vinyl area. She indicated she would get the resident a new mattress.</p> <p>On 6/3/13 at 1:15 P.M. CNA #5 was interviewed. She indicated Resident #40 is occasionally incontinent but for the most part is continent. She indicated when a resident is incontinent, she wipes the mattress down with soap and water as that is "what is handy."</p> <p>On 6/4/13 at 10 A.M., the Houskeeping Supervisor was interviewed. She indicated each resident room is deep cleaned once a month. She indicated this included but was not limited to, the following: bed stripped and wipe the frame and mattress down. She indicated at the time, when a resident is incontinent, the mattress should be cleaned with a general disinfectant. She indicated Resident #40's room was last deep cleaned on 5/10/13. At that time, the Housekeeping Supervisor indicted she had gone into the bathroom in Room 202. She indicated she did detect a strong urine odor and had the bathroom cleaned. She indicated she scrubbed the floor and the odor was "alittle better." She indicate she isn't sure where the odor is from.</p> <p>On 6/4/13 at 10:20 A.M., the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Houskeeping Supervisor provided a copy of the current policy and procedure for "Daily Patient Room Cleaning" and "Complete Room Cleaning." The policy was dated 1/1/2000. The Daily Room Cleaning procedure for the bathroom, included but was not limited to the following: "Damp mop floor, start in far corner. Get behind commode, move trash can, mop out the door."</p> <p>The "Complete Room Cleaning" was identified at that time by the Housekeeping Supervisor as the "deep cleaning" procedure. The procedure included but was not limited to, the following: "...clean the room... Additional work: clean and sanitize mattress..."</p> <p>2. On 5/28/13 at 11:36 A.M., the bathroom in room #111, which was shared by 2 residents, had a strong urine odor. Dried streaks of an unidentified liquid were running down the commode base and observed on the caulking between the commode and the tile floor. Urine odor permeated the resident's room.</p> <p>On 6/3/13 at 1:07 P.M., the bathroom in room #111 had a strong urine odor. A pool of unidentified liquid was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>observed at the commode base. While walking into the resident's bathroom, the floor was observed to be sticky and tacky. A strong urine odor permeated the resident's room.</p> <p>On 6/3/13 at 2:00 P.M., a strong urine odor permeated the bathroom in Room #111. The floor appeared to have been wet mopped but remained sticky and tacky. The water in the commode bowl was blue. Dried streaks of an unidentified liquid were running down the commode base.</p> <p>During an interview with the House Keeping Supervisor on 6/4/13 at 1:05 P.M., she indicated Room #111 was last deep cleaned on 5/2/13.</p> <p>During an interview with the Health Care Administrator (HCA) in Room #111, on 6/3/13 at 2:55 P.M., the HCA indicated she thought the tiles on the bathroom floor required replacement in order to eliminate the stong urine odor.</p> <p>3.1-19(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a resident with weight loss, had a plan of care to address nutrition/weight loss with interventions to prevent an unplanned weight loss for 1 of 3 residents reviewed for nutrition. Resident #42</p> <p>Findings include: On 5/31/13 at 11 A.M., the clinical record of Resident #42 was reviewed. Diagnosis included, but was not limited to, the following: unspecified</p>	F000279	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident receiving fortified cereal at breakfast and fortified mashed potatoes at lunch. IDT team monitors food intake during daily Clinical Start-up.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p>	07/03/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>disorder of the intestine and Alzheimers. The MDS (minimum data set assessment) dated 1/11/13 and 4/12/13 included, but were not limited to, the following: cognition identified as moderately impaired; eating required supervision/oversight; height was 66 inches; weight 1/11/13 (143 lb) and did not experience any weight loss; weight 4/12/13 (135 lb) and "yes" did experience weight loss and was not on a physician prescribed weight loss regimen.</p> <p>A physician order dated 7/6/12 and 2/26/13 indicated the following: monthly weights.</p> <p>A plan of care, dated 1/15/13, addressed the following problem: "Resident requires a Mechanically altered diet..." Interventions included, but were not limited to, the following: weight monthly, weigh weekly (no date was documented of this intervention).</p> <p>A Nutrition Assessment dated 1/16/13 included, but was not limited to, the following: "Resident continues to live in ACU (Alzheimers Care Unit) and eats in dining room...Has lost a little; non-significant weight x 90 days; Approx (approximately) 6%. Current weight of 143 #(pounds)...Will</p>		<p>All resident are monitored for food consumption on a daily basis during Clinical Start-up. Weekly weight meetings are conducted to review any resident with a weight loss from previous documented weight or any resident that we have already identified. Registered Dietician to be notified of significant change in weight and care plan initiated and updated as deemed necessary by weekly weight meeting recommendations.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>All resident are monitored for food consumption on a daily basis during Clinical Start-up. Weekly weight meetings are conducted to review any resident with a weight loss from previous documented weight or any resident that we have already identified. Registered Dietician to be notified of significant change in weight and care plan initiated and updated as deemed necessary by weekly weight meeting recommendations</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>continue to monitor monthly...No recommendations at this time."</p> <p>A nurses note dated 3/6/13, indicated "continues to have issue with weight loss..."</p> <p>A note by the FSM, dated 3/7/13, indicated the following: "...Placed on weight meetings due to weight loss. Weight 158# (pounds) in Sept (September) 2012. Now weight 140# in March 2013...Weight 139 (sic) on 3/3/2013. Sending Hi Cal (calorie) cereal...for bk (breakfast)."</p> <p>A note by the FSM, dated 4/12/13, indicated the following: "IDT (Interdisciplinary Team): "...Placed on weight meetings due to weight loss. Weight 158# in Sept (September) 2012. Now weight 140# in March 2013...Weight 139 (sic) on 3/3/2013. Weight 141# on 3/9/13. Weight 141# on 3/18/13. Weight 141.5# on 3/25/13. Weight 135# on 4/4/13. Sending Hi Cal (calorie) cereal...for bk (breakfast). Will continue. "</p> <p>A quarterly nutrition assessment, dated 5/14/13, indicated the following: "Resident...has loss 10% in past 180 days. On weekly weights and weight meetings. Sending hi cal (calorie)</p>		<p>quality assurance program will be put into place:</p> <p>Weekly weight meetings will be conducted to review any resident with a weight loss or any resident that we have already identified with a loss. This will also be reviewed during our monthly QAPI meeting times 4 months and then quarterly as needed.</p> <p>Date the systemic changes will be completed: 7/3/13.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>cereal..will continue to monitor weight..."</p> <p>A progress note from the Dietician was dated 5/29/13 and included, but was not limited to, the following: "...wts (weights) included 5/25: 134#; 4/22: 136#; 2/25: 139#, 11/9/12: 154#. no sig (significant) weight changes past 30, 90 days; 13% /20# weight loss x 180 days;...however best consumption patterns seen at dinner meal; recommend add enhanced mashed potatoes to dinner."</p> <p>On 6/3/13 at 11:50 A.M., the Dietician was interviewed. At that time, she provided the following: a meal report for the dates of 12/5/12 to 6/3/13. The form indicated the resident ate an average of 92% for breakfast; 78% for lunch and 85% for dinner. At that time, the Dietician also provided a current weight log, which included weights from 6/10/11 (153 lbs) to the most recent weight of 5/25/13 (134).</p> <p>The Dietician indicated at that time, Resident#42 was started on a daily high calorie cereal with breakfast on 3/7/13. She indicated the designation of "standing" and "lift" indicated which type of scale the resident was weighed on.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3/25/13= 141.5 lb (standing) 3/31/13= 134.8 lb (lift) 4/4/13= 135 lb 4/6/13= 139 lb. 4/15/13= 134 lb 5/10/13= 138 lb 5/13/13= 136 lb 5/25/13= 134 lb.</p> <p>The Dietician indicated at that time, the resident was started on fortified mashed potatoes daily with his evening meal on 5/29/13, due to the resident's significant weight loss within 180 days. She indicated the resident's weight on 11/9/12 was 154 lb and on 5/25/13 was 134 lbs. She indicated at the time, the weight loss was gradual and the resident is currently on weekly weights.</p> <p>At that time, the Dietician indicated the fortified mashed potatoes were added due to the resident continuing to experience weight loss. The Dietician indicated, the FSM (Food Service Manager) monitors the weights weekly. The Dietician indicated the only two dietary interventions recommended for the resident in the year 2013, were on 3/7/13 and 5/29/13.</p> <p>On 6/4/13 at 8:35 A.M., the FSM was interviewed. She indicated the resident had been on weekly weights</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>at least since March and she reviews the weights weekly. The FSM indicated the resident was a concern to her because he started "losing weight." The FSM indicated the resident's weight has been a concern to her since November - December 2012.</p> <p>The FSM indicated at that time, she typically wouldn't have waited from March, when the hi cal cereal was added, until May 2013 before adding an additional supplement. The FSM indicated the resident was eating 82% of his meals and still had weight loss. She indicated she doesn't understand this but the resident's weight was a concern. She also reviewed the resident's clinical record at this time and indicated there is no care plan for the resident to address weight loss/nutrition.</p> <p>On 6/4/13 at 9:50 A.M., the ADN (Assistant Director of Nursing) provided a current copy of the policy and procedure for "Weight Monitoring." The policy and procedure was dated 2011. The policy included, but was not limited to, the following: To monitor nutrition and hydration height and weight will be obtained...All weights will be reviewed by the DSM (Dietary Service</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Manager) and the RD (Registered Dietician) will be notified of any significant weight changes or trends throughout the referral process."</p> <p>3.1-35(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review the facility failed to ensure the care plan had been followed in regard to toileting for 1 of 2 residents reviewed for urinary incontinence in the stage 2 sample. Resident #46</p> <p>Findings include:</p> <p>On 5/30/13 at 9:05 A.M., CNA #1 and CNA #2, were observed to ask Resident #46 to stand from her recliner and hold on to the walker they had placed in front of her. They then removed her disposable brief, provided peri care, and then applied a disposable brief. No opportunity to toilet had been provided. Resident #46 remained in her recliner until 11:35 A.M., when CNA #1 and CNA #2, were observed assisted her to walk to the dining room from her room. CNA #1 and CNA #2 were interviewed at that time regarding care provided before ambulation. They indicated they had assisted her</p>	F000282	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Review resident care plan and update to reflect current condition. CNA assignment sheets are updated to reflect current condition and needs of the resident.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>IDT Team will review care plans, CNA assignment sheets of residents who have the potential to be affected by the same deficient practice</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Nursing administration/Charge Nurse or designee will monitor nursing staff to ensure compliance with care plans as</p>	07/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>up from her recliner using a gait belt and had assisted her to walk to the dining room.</p> <p>On 5/30/13 at 1:05 P.M., CNA #2 asked Resident # 46 if she needed to go to the bathroom. Resident #46 indicated "no." A few seconds later CNA #1 asked Resident #46 to go to the bathroom. Resident #46 agreed to go to the bathroom. She was assisted to toilet per CNA #1 and CNA #2. CNA #2 indicated the resident had voided in the commode. CNA #1 indicated Resident #46 "quite often" voids in the commode.</p> <p>On 5/30/13 at 12:20 P.M., Resident #46's clinical record was reviewed. Diagnoses included but were not limited to: senile dementia with delirium, and anxiety state. She had been admitted to the facility on 1/11/13.</p> <p>Her Minimum Data Set Assessment (MDS) dated 1/20/13, indicated the physical assistance of 2 staff for toilet use. The documentation indicated Resident #46 had frequent incontinence of 7 or more episodes of urine incontinence and at least 1 episode of continent voiding. The current MDS dated 4/22/13, indicated the physical assistance of 2 staff for</p>		<p>reflected in the nursing assignment sheets to provide correct level of care required by each resident.</p> <p>Nursing Administration/Charge Nurse or designee will conduct visual monitoring 5 times weekly for 4 weeks, then 3 times weekly for 3 weeks, then weekly for 3 weeks of resident care to ensure staff are following residents individual care plan. (Addendum: Nursing Administration or designee will on a monthly basis review CNA assignment sheets vs. care plan to ensure they are accurate. Nursing staff inserviced on Bowel and Bladder Care and Training.)</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Nursing administration/Charge Nurse or designee will monitor nursing staff to ensure compliance with care plans as reflected in the nursing assignment sheets to provide correct level of care required by each resident.</p> <p>Nursing Administration/Charge Nurse or designee will conduct visual monitoring 5 times weekly for 4 weeks, then 3 times weekly for 3 weeks, then weekly for 3 weeks of resident care to ensure staff are following residents</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>toilet use and always incontinent with no episodes of continence.</p> <p>On 6/3/13 at 1:10 P.M., the Director of Nursing (DON) was made aware of the lack of toileting opportunities provided (2 of 3 opportunities) on 5/30/13, day shift when nursing care had been monitored. The DON was made aware of the resident's current care plan included a toileting plans. The DON indicated at that time Resident #46 needed to be provided toileting opportunities.</p> <p>On 6/3/13 at 4:12 P.M., the DON provided copies of current care plan (initiation date 4/23/13) that included but was not limited to: "...Assist to bathroom upon rising, before and after meals, hs and prn (as needed)..."</p> <p>3.1-35(g)(2)</p>		<p>individual care plan. This will be monitored during facility monthly QAPI meeting.(Addendum: Monthly times 4 months, then quarterly times 3 then as necessary.)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(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			
F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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 ensure a resident had been provided opportunities to toilet for 1 of 2 residents who met the criteria for urinary incontinence in the stage 2 sample. Resident #46</p> <p>Findings include:</p> <p>On 5/30/13 at 9:05 A.M., CNA #1 and CNA #2, were observed to ask Resident #46 to stand from her recliner and hold on to the walker they had placed in front of her. They then removed her disposable brief, provided peri care, and then applied a disposable brief. No opportunity to toilet had been provided. Resident #46 remained in her recliner until 11:35 A.M., when CNA #1 and CNA #2, were observed</p>	F000315	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Review resident care plan and update to reflect current condition. CNA assignment sheets are updated to reflect current condition and needs of the resident.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>IDT Team will review care plans, CNA assignment sheets of residents who have the potential to be affected by the same deficient practice</p> <p>What measures will be put into</p>	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>assisted her to walk to the dining room from her room. CNA #1 and CNA #2 were interviewed at that time regarding care provided before ambulation. They indicated they had assisted her up from her recliner using a gait belt and had assisted her to walk to the dining room.</p> <p>On 5/30/13 at 1:05 P.M., CNA #2 asked Resident # 46 if she needed to go to the bathroom. Resident #46 indicated "no." A few seconds later CNA #1 asked Resident #46 to go to the bathroom. Resident #46 agreed to go to the bathroom. She was assisted to toilet per CNA #1 and CNA #2. CNA #2 indicated the resident had voided in the commode. CNA #1 indicated Resident #46 "quite often" voids in the commode.</p> <p>On 5/30/13 at 12:20 P.M., Resident #46's clinical record was reviewed. Diagnoses included but were not limited to: senile dementia with delirium, and anxiety state. She had been admitted to the facility on 1/11/13.</p> <p>Her Minimum Data Set Assessment (MDS) dated 1/20/13, indicated the physical assistance of 2 staff for toilet use. The documentation indicated Resident #46 had frequent incontinence of 7 or more episodes of</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Nursing administration/Charge Nurse or designee will monitor nursing staff to ensure compliance with care plans as reflected in the nursing assignment sheets to provide correct level of care required by each resident.</p> <p>Nursing Administration/Charge Nurse or designee will conduct visual monitoring 5 times weekly for 4 weeks, then 3 times weekly for 3 weeks, then weekly for 3 weeks of resident care to ensure staff are following residents individual care plan.</p> <p>(Addendum: Nursing Administration or designee will on a monthly basis review CNA assignment sheets vs. care plan to ensure they are accurate. Nursing staff in serviced on Bowel and Bladder Care and Training.)</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Nursing administration/Charge Nurse or designee will monitor nursing staff to ensure compliance with care plans as reflected in the nursing assignment sheets to provide</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>urine incontinence and at least 1 episode of continent voiding. The current MDS dated 4/22/13, indicated the physical assistance of 2 staff for toilet use and always incontinent with no episodes of continence.</p> <p>On 6/3/13 at 1:10 P.M., the Director of Nursing (DON) was made aware of the lack of toileting opportunities provided (2 of 3 opportunities) on 5/30/13, day shift when nursing care had been monitored. The DON was made aware of the CNA assignment sheet and the resident's current care plan had included toileting plans. The DON indicated at that time Resident #46 needed to be provided toileting opportunities.</p> <p>The CNA assignment sheet received on 5/30/13 at 9:20 A.M., indicated for Resident #46, "...Toileting program: take to bathroom upon rising, before and after meals, at bedtime, and as needed..."</p> <p>On 6/3/13 at 4:12 P.M., the DON provided copies of current care plan (initiation date 4/23/13) that included but was not limited to: "...Assist to bathroom upon rising, before and after meals, hs and prn (as needed)..."</p>		<p>correct level of care required by each resident.</p> <p>Nursing Administration/Charge Nurse or designee will conduct visual monitoring 5 times weekly for 4 weeks, then 3 times weekly for 3 weeks, then weekly for 3 weeks of resident care to ensure staff are following residents individual care plan. This will be monitored during facility monthly QAPI meeting. (Addendum: Monthly times 4 months, then quarterly times 3 then as necessary.)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
	3.1-41(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(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			
F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation , record review and interview, the facility failed to provide safety of residents from hazard posed by 1 of 1 wandering resident observed on the Alzheimer ' s unit. This had the potential to impact 21 other residents on the unit. Resident #78</p> <p>Findings include: On 5/29/13 at 9:15 A.M., Resident #78 was observed self propelling herself in a wheel chair about the unit. In the lounge area she backed into an empty chair and then propelled forward over the little toe on the right foot of Resident #21. Resident #21 hollered aloud and LPN #1 responded. The LPN checked the toe and indicated " Oh, it is red. " Resident #21 was able to ambulate with the nurse without any discomfort. Resident #78 was observed to continue self propelling around the unit.</p>	F000323	<p>Corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident was transferred to a stationary chair on 05/29/13 with staff supervision and activities provided. Care plan was revised to reflect resident to be assisted to stationary chairs/recliner for activities and meals. Facility to maintain a clutter free environment, as is possible, without hindering their independence to ensure hazards or accidents do not occur.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>Any resident who has cognitive deficient who require a wheelchair for primary method of locomotion will be assessed for safety awareness. Facility to maintain a clutter free environment, as is possible, without hindering their independence to ensure hazards</p>	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 5/29/13 at 9:30 A.M., Resident # 2 was observed seated on the faux porch. The porch had been constructed with railings and a single entry/exit. Resident # 2 was seated in a wicker rocker with her walker parked to her right side and her left knee crossed over her right knee. Resident #78 entered the porch to the left of Resident #2 and snagged the left foot of Resident # 2 in the spokes of her wheel chair. Resident # 2 quickly pulled her left foot back from the wheel, withdrew her feet below her and pulled her walker in front of her as a guard while pushing Resident #78 back into the porch entrance. The area was unsupervised during the incident.</p> <p>On 5/29/13 at 10:00 A.M., the clinical record of Resident #78 was reviewed. The resident's diagnoses included Dementia with behavioral disturbance and psychosis. There was a Social Service assessment note on 5/23/13 which documented the resident admission from a behavioral management, related to her dementia, and her adjustment phase on the Alzheimer ' s unit.</p> <p>The 5/09/13 care plan addressed problems of moderate to severe cognitive loss with one intervention "</p>		<p>or accidents do not occur.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Any resident who has cognitive deficient who require a wheelchair for primary method of locomotion will be assessed for safety awareness. Update care plan as indicated. Facility to maintain a clutter free environment, as is possible, without hindering their independence to ensure hazards or accidents do not occur.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>IDT Team and Therapy will review resident's abilities and safety awareness to protect them and other residents while maintaining their highest individual level of functional independence. This will be reviewed during monthly QAPI meeting times 4 months, then quarterly times 3 and as needed.</p> <p>Date the systemic changes will be completed: 7/3/13.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>propels self in wheel chair throughout the Alzheimer ' s Care Unit.</p> <p>The 5/9 care plan also addressed the problem phrased " I have little or no awareness of safety, or boundries related to other ' s personal space, Please help me remain in a living environment that meets and supports my need to safely wander such as a secured unit or specialized care unit. Not always aware if areas are okay for me to be in. "</p> <p>Interventions did not address the hazard posed to other residents.</p> <p>Documentation was lacking to indicate a plan to ensure safety of all residents on the Alzheimer ' s unit.</p> <p>On 5/29/13 at 10:00 A.M., the Director of Nursing, formerly the Alzheimer ' s unit Director was interviewed regarding the above. She indicated the care team would have to consider a plan to permit wheel chair use only with direct supervision.</p> <p>On 5/30/13 at 12:30 P.M., the July 2006 Policy and Procedure for Mood / Behavior Management was reviewed. It directed " ...assess resident ' s behaviors that are potentially harmful to self or others.. "</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
	3.1-45(a)(1) 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(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			
F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident had interventions implemented in an attempt to prevent unplanned weight loss for 1 of 3 residents reviewed for nutrition. Resident #42</p> <p>Findings include:</p> <p>On 5/31/13 at 11 A.M., the clinical record of Resident #42 was reviewed. Diagnosis included, but was not limited to, the following: unspecified disorder of the intestine and Alzheimers. The MDS (minimum data set assessment) dated 1/11/13 and 4/12/13 included, but were not limited to, the following: cognition identified as moderately impaired; eating required supervision/oversight; height was 66 inches; weight 1/11/13 (143 lb) and did not experience any weight loss; weight 4/12/13 (135 lb)</p>	F000325	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident receives fortified oats for breakfast and fortified mashed potatoes for lunch. RD reviewed with additional supplement ordered with med pass. Continues with weekly weights.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents have the potential to be affected by the same deficient practice. DSM/ IDT-team to hold comprehensive weekly Weight Meetings which reviews weights, intakes, effectiveness of current interventions, and care-plan adjustments. Those residents trending will be referred to the</p>	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and "yes" did experience weight loss and was not on a physician prescribed weight loss regimen.</p> <p>A physician order dated 7/6/12 and 2/26/13 indicated the following: regular mechanical soft diet and monthly weights.</p> <p>A plan of care, dated 1/15/13, addressed the following problem: "Resident requires a Mechanically altered diet..." Interventions included, but were not limited to, the following: weight monthly, weigh weekly (no date was documented of this intervention).</p> <p>A Nutrition Assessment dated 1/16/13 included, but was not limited to, the following: "nutrition diagnosis" was left blank; "Resident continues to live in ACU (Alzheimers Care Unit) and eats in dining room...Consuming average of 93% of meals. Intake is exceeding estimated nutrient needs. Receiving...Mech (mechanical) soft diet. Has lost a little; non-significant weight x 90 days; Approx (approximately) 6%. Current weight of 143 #(pounds)...Will continue to monitor monthly...No recommendations at this time."</p> <p>A nurses note dated 3/6/13, indicated</p>		<p>Registered Dietitian for further follow-up.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>DSM/ IDT-team to hold comprehensive weekly Weight Meetings which reviews weights, intakes, effectiveness of current interventions, and care-plan adjustments. Those residents trending will be referred to the Registered Dietitian for further follow-up.</p> <p>-DSM to begin utilizing "Weight Monitor-Excel" to accurately track weekly weight variances.</p> <p>- RD/DSM and IDT-team to review those residents who are triggering for significant weight changes (Addendum:Weekly)</p> <p>-RD/DSM to conduct pro-active review of those with non-significant, but trending weight changes (identified through Weight Monitor-Excel)</p> <p>How the corrective action will be monitored to ensure that the deficiency practice will not recur, i.e., what quality assurance program will be put into place: DSM/IDT team will conduct weekly comprehensive Weight Meetings and review results in facility monthly QAPI meetings for (Addendum: 4 months then</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>"continues to have issue with weight loss..."</p> <p>A note by the FSM, dated 3/7/13, indicated the following: "...Placed on weight meetings due to weight loss. Weight 158# (pounds) in Sept (September) 2012. Now weight 140# in March 2013...Weight 139 (sic) on 3/3/2013. Sending Hi Cal (calorie) cereal...for bk (breakfast)."</p> <p>A physician progress note dated 3/22/13 indicated the following: On Alzheimers unit; continue to do fairly well; forgetful and has gotten more confused; likes to smoke a lot; eats fair.</p> <p>A "Quarterly Interdisciplinary Resident Review" form dated 4/8/13 indicated the following: "Weight loss last 30 days or 180 days (was left blank)..."</p> <p>A note by the FSM, dated 4/12/13, indicated the following: "IDT (Interdisciplinary Team): "...Placed on weight meetings due to weight loss. Weight 158# in Sept (September) 2012. Now weight 140# in March 2013...Weight 139 (sic) on 3/3/2013. Weight 141# on 3/9/13. Weight 141# on 3/18/13. Weight 141.5# on 3/25/13. Weight 135# on 4/4/13. Sending Hi Cal (calorie)</p>		<p>quarterly times 3, then as necessary.) 3 months then quarterly times 3 then as necessary.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>cereal...for bk (breakfast). Will continue. "</p> <p>A quarterly nutrition assessment, dated 5/14/13, indicated the following: "Resident...has loss 10% in past 180 days. On weekly weights and weight meetings. Sending hi cal (calorie) cereal...will continue to monitor weight..."</p> <p>A progress note from the Dietician was dated 5/29/13 and included, but was not limited to, the following: "...wts (weights) included 5/25: 134#; 4/22: 136#; 2/25: 139#, 11/9/12: 154#. no sig (significant) weight changes past 30, 90 days; 13% /20# weight loss x 180 days;...however best consumption patterns seen at dinner meal; recommend add enhanced mashed potatoes to dinner."</p> <p>On 5/30/13 at 12:56 P.M., Resident #42 was observed to be eating in the ACU (Alzheimers Care Unit). The resident was observed eating independently and had eaten a total of 30% of his lunch.</p> <p>On 6/3/13 at 11:50 A.M., the Dietician was interviewed. At that time, she provided the following: a meal report for the dates of 12/5/12 to 6/3/13. The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>form indicated the resident ate an average of 92% for breakfast; 78% for lunch and 85% for dinner. At that time, the Dietician also provided a current weight log, which included weights from 6/10/11 (153 lbs) to the most recent weight of 5/25/13 (134).</p> <p>Weights included, but not limited to, the following: 10/12/12= 152 lb 12/10/12=148 lb 1/9/13= 143 lb 2/25/13= 139 lb 3/3/13 = 139 lb</p> <p>The Dietician indicated at the time, Resident #42 was started on a daily high calorie cereal with breakfast on 3/7/13. She indicated the designation of "standing" and "lift" indicated which type of scale the resident was weighed on. 3/10/13= 141 lb 3/25/13= 141.5 lb (standing) 3/31/13= 134.8 lb (lift) 4/4/13= 135 lb 4/6/13= 139 lb. 4/15/13= 134 lb 5/10/13= 138 lb 5/13/13= 136 lb 5/25/13= 134 lb.</p> <p>The Dietician indicated at that time, the resident was started on fortified mashed potatoes daily with his evening meal on 5/29/13, due to the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident's significant weight loss within 180 days. She indicated the resident's weight on 11/9/12 was 154 lb and on 5/25/13 was 134 lbs. She indicated at the time, the weight loss was gradual and the resident is currently on weekly weights.</p> <p>At that time, the Dietician indicated the fortified mashed potatoes were added due to the resident continuing to experience weight loss. The Dietician indicated, the possible reason for the fluctuation in weights from 3/25/13 (141.5 lb) to 3/31/13 (134.8 lb, a 6.7 lb weight loss) could have been due to the resident being weighed on a different type scale. She indicated at the time, that ideally, the facility would have gotten a reweight (due to the 6.7 lb weight loss) sooner than the next documented weight on 4/4/13. The weight of 135 lb on 4/4/13, lacked documentation of the type of lift which was used to weigh the resident on this date. The Dietician indicated at the time, the FSM (Food Service Manager) monitors the weights weekly. The Dietician indicated the only two dietary interventions recommended for the resident in the year 2013, were on 3/7/13 and 5/29/13.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>At that time, the Dietician indicated the resident's ideal body weight was 128 lb. - 156 lbs. She indicated at that time, all the weights and reweights were on the computer.</p> <p>On 6/3/13 at 2:30 P.M., the FSM (food service manager) was interviewed. She indicated she reviews the weights monthly and if a resident has a significant weight loss the resident was reweighed within 48 hours.</p> <p>On 6/4/13 at 8:35 A.M., the FSM was interviewed. She indicated she monitors weights weekly. She indicated the resident had been on weekly weights at least since March. The FSM indicated the resident was a concern to her because he started "losing weight." She indicated if a resident loses weight of significant amount it is a concern to her. The FSM indicated the resident 's weight has been a concern to her since November - December 2012. The FSM stated she tells the staff when to do reweights. She stated reweights should be done within 24 - 48 hours. She indicated on 3/31/13, the resident wasn't reweigh because it was a weekend and she is off. The FSM indicated the staff indicated to her the weights "may not be accurate</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>because it depends how the resident stands on the scale." She indicated that may be the reason for the fluctuation in weights.</p> <p>The FSM indicated at that time, she typically wouldn't have waited from March, when the hi cal cereal was added, until May 2013 before adding an additional supplement. The FSM indicated the resident was eating 82% of his meals and still had weight loss. She indicated she doesn't understand this but the resident's weight was a concern. She also reviewed the resident's clinical record at the time and indicated there is no care plan for the resident to address weight loss/nutrition.</p> <p>On 6/4/13 at 9:50 A.M., the ADN (Assistant Director of Nursing) provided a current copy of the policy and procedure for "Weight Monitoring." The policy and procedure was dated 2011. The policy included, but was not limited to, the following: To monitor nutrition and hydration height and weight will be obtained...All weights will be reviewed by the DSM (Dietary Service Manager) and the RD (Registered Dietician) will be notified of any significant weight changes or trends throughout the referral process."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
	3.1-46(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(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			
F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to date left over frozen food items, provide adequate handwashing, and /or ensure sanitary food preparation procedures were maintained for 2 of 2 survey days. This potentially affected 54 of 56 residents who received their meals from the facility kitchen.</p> <p>Findings include: On 5/28/13, the following were observed on initial tour of the kitchen:</p> <p>1. On 5/28/13 at 9:05 A.M., on the initial tour of the kitchen the Food Service Manager (FSM) observed that the lid of the trash container by the hand sink was on the floor. The FSM picked up the trash container lid off the floor and placed it on top of the trash container. She then removed clean drinking glasses from a shelf unit that had come out of the dishwasher. She continued to move the clean drinking glasses to a</p>	F000371	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Staff to utilize safe food-handling practices including, but not limited to: proper hand washing, proper labeling/dating of food items, proper glove usage and proper cleaning/sanitation of the kitchen.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents receiving an oral diet are having the potential to be affected by the same deficient practice. Staff to utilize safe food handling practices; Routine cleaning schedules will be followed.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the</p>	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>shelving unit to air dry without hand washing.</p> <p>2. On 5/28/13 at 9:35 A.M., the walk-in refrigerator was toured and the FSM was unable to find a thermometer in the walk- in refrigerator.</p> <p>3. During tour of the walk in freezer, 5 plastic storage bags containing frozen mushrooms were labeled in amounts of 1 cup and 1/2 cups. The storage bags did not include a date. The FSM on interview at that time indicated the mushrooms should include the date the food was placed in the freezer. The FSM dropped 2 bags of the mushrooms on the freezer floor and went to discard them in a large plastic trash can that had a large round lid in place. She had to move the lid to one side to discard the mushrooms and did not hand wash after handling the trash can lid.</p> <p>4. Next at 9:39 A.M., on 5/28/13, the dry pantry area of the kitchen was toured. Two plastic bucket containers of sugar and flour were noted to have soiling of the lids with dried food particles of sugar and flour.</p> <p>On 5/31/13, the following was</p>		<p>deficient practice does not recur:</p> <p>DSM/RD will conduct in-services with all dietary staff on proper hand washing procedures, labeling/dating of food items, and glove usage. Routine cleaning schedules for the walk-in refrigerator/freezer floor and ceiling vents will be implemented. (Addendum: DSM/RD or designee to complete the "Dietary Sanitation Quality Indicators" audit, which includes food preparation and service is done with proper utensils, twice weekly for 4 weeks, weekly for 3 weeks, then as indicated.)</p> <p>How the corrective action will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>DSM/RD or designee to complete the "Dietary Sanitation Quality Indicators" Audit twice weekly for 4 weeks, weekly for 3 weeks, then prn with follow-up staff education/correction as needed. This will be reviewed during our monthly QAPI for 4 months then quarterly times 3 (Addendum: then as necessary.)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>observed in the kitchen:</p> <p>5. On 5/31/13 at 11:40 A.M., Dietary staff #1 left the serving line and returned with 2 slices of ham. She laid the ham slices wrapped in a napkin on the metal surface of the milk cooler. The corner of the ham slices were in contact with the metal surface of the cooler.</p> <p>6. On 5/31/13 at 1:30 P.M., the floor of the walk-in refrigerator was observed to have black soil in the floor panel seams. The FSM indicated at that time the maintenance staff needed to fix the caulking of the floor panel seams.</p> <p>7. On 5/31/13 at 1:30 P.M., 3 ceiling vents near the entrance of the kitchen had black soil on the metal edges. The FSM at that time indicated that maintenance staff usually clean the ceiling vents.</p> <p>8. On 6/3/13 at 1:40 P.M., the FSM was interviewed regarding hand sanitation in the kitchen. She indicated she was aware there was a problem with handling items on the floor and trash can lids without hand washing. She also indicated the walk in freezer floor had now been cleaned and maintenance staff had reapplied</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>caulking. She indicated the soiled ceiling vents had been cleaned on the day she was made aware of the soiling. She also indicated Dietary Staff #1 would be inserviced on the handling of food items.</p> <p>On 6/3/13 at 2:50 P.M., the FSM provided facility policies on hand washing and daily and weekly cleaning schedules. The hand washing policy (dated 2011) included but was not limited to: when to wash hands. "... Wash hands and exposed forearms: ...After handling any soiled or contaminated equipment, cleaning cloths, utensils, dish trays, soiled aprons, can lids,..." The FSM at that time also provided a blank weekly cleaning schedule which included to clean walk -in freezer and refrigerator floors weekly (sweep and mop). The FSM indicated at that time she was going to change the cleaning solution used to clean the floor of the walk-in refrigerator floor.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=D	<p>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> <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</p>	F000441	How other residents having the potential to be affected by the	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ensure adequate hand washing and/or handling of clean supplies was performed by the facility staff, for 1 of 1 dressing changes observed. Resident # 5</p> <p>Findings include:</p> <p>Resident #5's clinical record was reviewed on 5/31/13 at 9:15 A.M. Her current treatment order initiated 12/12/12, indicated, "Pack rt (right) hip wound bid (twice a day) with plain packing gauze and cover with mepore (dressing)- Two times a day Everyday."</p> <p>On 5/31/13 at 9:52 A.M., LPN #1 indicated she was going to do a dressing change to Resident #5's stage 4 pressure of the right hip. LPN #1 placed a towel on the resident's bed side table and positioned her supplies on the towel. She also placed towels on the bed and plastic bags at the foot of the bed. She washed her hands and applied gloves before removing the gauze packing of the wound and the outside mepore dressing. Bloody drainage was observed on the gauze packing when the dressing was removed. No handwashing or clean gloves were applied before the new packing was applied. The new packing was cut</p>		<p>same deficient practice will be identified and what corrective action will be taken: All residents with dressing changes will be preformed within the scope and accuracy of the Infection Control Policy and Procedure. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Licensed staff will be in-service in regards to infection control procedures during dressing changes. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Nursing Administration will observe and check off licensed nurses on return demonstration to ensure that proper protocols are in use and being utilized.</p> <p>(Addendum: Nursing Administration will monitor dressing changes per physician order, twice weekly for 4 weeks then 1 time weekly for 4 weeks. (Addendum: Nursing staff in serviced on infection control. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Nursing Administration will observe and check off licensed nurses on return demonstration to ensure that proper protocols are in use and being utilized.</p> <p>N(Addendum: Nursing</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>with scissors (not bandage). The packing was applied with a q-tip and then a mepore dressing was applied. LPN #1 then removed her gloves and washed her hands before dating and initialing the new mepore dressing. She placed the scissors she had used into the pocket of her uniform. LPN #1 exited the resident's room and entered the soiled utility room to discard soiled supplies. She was then observed washing her hands in the sink in the soiled utility room with clean dressing supplies in a small plastic bag laying on the surface of the utility room sink.</p> <p>On 6/3/13 at 1:13P.M., the Director of Nursing (DON) was interviewed regarding dressing changes. The DON was made aware of the lack of hand washing and glove change between the removal of the soiled dressing and the new dressing applied during the dressing change of Resident #5. The DON indicated at that time that gloves should be removed and hands washed after a soiled dressing removal and before applying a new dressing.</p> <p>On 6/3/13 at 1:23 P.M., the current facility policy (dated May 2001) entitled "Dressing Change (Clean)" was reviewed with the DON. The</p>		<p>Administration will monitor dressing changes per physician order, twice weekly for 4 weeks then 1 time weekly for 4 weeks. This will be reviewed monthly in facility QAPI meeting for 4 months then quarterly (Addendum: times 3 then)as necessary.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>policy included but was not limited to: " ...5 Put on first pair of disposable gloves. 6 Removed soiled dressing and discard in plastic bag. 7 Dispose of gloves in plastic bag. 8 Put on second pair of disposable gloves..." The DON indicated at that time when gloves were removed after a soiled dressing change hand washing was needed before new gloves and a new dressing were applied. She indicated she was going to review the facility's current policy (Dressing Change (Clean) 2001) in regard to handwashing lacking after soiled gloves were removed.</p> <p>On 6/4/13 at 12:43 P.M., the Assistant Director of Nursing (ADON) provided a document entitled, "Clean Dressing Change Audit." The ADON indicated in April 2013, all nursing staff had been inserviced on the procedure of a clean dressing change. The document indicated, "...7 Put on first pair of disposable gloves, 8 Remove soiled dressing...9 Dispose of gloves in plastic bag, 10 Wash hands and put on clean pair of gloves..."</p> <p>3.1-18(b)(1) 3.1-18(l)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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