

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00185212 and IN00184626.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00187055.</p> <p>Complaint IN00185212 - Substantiated. No Federal/State deficiencies related to the allegations are cited.</p> <p>Complaint IN00184626 - Substantiated. No Federal/State deficiencies related to the allegations are cited.</p> <p>Survey dates: November 9,10, 12, 13, 14, 17, 18 and 19, 2015.</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Census bed type: SNF/NF: 142 Total: 142</p> <p>Census payor type: Medicare: 18 Medicaid: 95</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>Other: 29 Total: 142</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on November 24, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment</p>			
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	<p>significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's Physician of abnormal lab results for 1 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria for unnecessary medications. (Resident #107)</p> <p>Finding includes:</p> <p>The record for Resident #107 was reviewed on 11/12/15 at 10:52 a.m. Diagnoses included, but were not limited to, diabetes mellitus, dementia with behaviors, and major depressive disorder.</p> <p>Current Physician Orders included: A1C level (measures blood sugar over</p>	F 0157	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 11.19.15, MD was notified of the lab results for resident #107. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents with a change in condition have the potential to be affected by the deficient practice. Residents with lab orders had their most recent lab audited for MD notification. Residents that had a change of condition were reviewed. Residents missing documentation of MD notification had the MD notified and documentation completed. 3.</p>	12/31/2015

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	<p>time) every three months.</p> <p>Review of the A1C lab results indicated the following: 4/6/15 7.9 High (normal value 4.4-6.3) 4/20/15 7.7 High 7/6/15 7.5 High 10/5/15 7.8 High</p> <p>Review of Progress Notes from April 2016 until present indicated the following: - 4/19/15 "Dr. [Physician's name] in facility reviewed labs & blood sugars orders received to repeat A1C" - 4/23/15 "Received A1C results 7.7 MD notified of results. No new orders received." There was no documentation indicating the Physician was notified of high A1C levels on 4/6/15, 7/6/15, or 10/5/15.</p> <p>Interview with the D Wing Unit Manager (UM) on 11/13/15 at 9:52 a.m., indicated the nurses should have documented physician notification of abnormal lab results in the Progress Notes. They would also usually write on the lab result copy.</p> <p>Interview with the DON (Director of Nursing) on 11/17/15 at 2:49 p.m., indicated no documentation was found in the Progress Notes or elsewhere to indicate the Physician was notified of</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: Nurses were educated on MD notification for any change of condition including abnormal labs. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Unit Managers will complete the Lab Audit 5x/weekly to ensure there is documentation of physician notification of abnormal lab results. Unit managers will continue to complete change of condition audit tool 5x/weekly for 6 months. Results of the audit will be reviewed by the DNS to identify any facility trends or patterns. Results will be submitted to QAPI with compliance percentages for review and recommendations monthly for 6 months.</p>	

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F 0159 SS=B Bldg. 00	<p>abnormal lab results for Resident #107.</p> <p>3.1-5(a)(2)</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the</p>			

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	<p>facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interview the facility failed to provide residents access to their personal funds account on an ongoing basis for 3 of 3 residents reviewed for personal funds. (Resident #15, #27, and #40)</p> <p>Findings include:</p> <p>1. During an interview with Resident #27 on 11/10/15 at 10:35 a.m. he indicated he was unable to get money out of his personal funds account after 4:00 p.m. on weekdays and could not get money out at all on the weekends.</p>	F 0159	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Res #15, #27 and #40 were notified verbally and in writing of personal fund access availability after hours on November 18, 2015.2. How other resident having the potential to be affected by the same deficient practice will be identified and dwhat corrective action will be taken:Whole house audit of residents that currently have resident trust accounts completed on November 18, 2015. 123 residents had the potential of being affected. All residents were notified verbally and in writing of after hours</p>	12/31/2015			

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	<p>Resident #27's record was reviewed on 11/18/15 at 2:15 p.m. The 10/17/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact.</p> <p>2. During an interview with Resident #40 on 11/10/15 at 10:07 a.m. she indicated she was unable to get money out of her personal funds account on the weekends.</p> <p>Resident #40's record was reviewed on 11/18/15 at 2:16 p.m. The 9/14/15 Quarterly MDS assessment indicated the resident was cognitively intact.</p> <p>3. During an interview with Resident #15 on 11/9/15 at 3:31 p.m. she indicated she was unable to get money out of her personal funds account on the weekends.</p> <p>Resident #15's record was reviewed on 11/18/15 at 2:17 p.m. The 8/4/15 Annual MDS assessment indicated the resident was cognitively intact.</p> <p>During an interview with the Business Office Manager #1 on 11/18/15 at 1:50 p.m. she indicated she didn't think residents could not get their money out after 4:00 p.m. She further indicated on the weekends the weekend manager was supposed to keep a locked box with</p>		<p>personal fund access on November 18, 2015. POAs were notified in writing by mail on November 19, 2015.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Business Office staff were educated on November 18, 2015. Facility staff education to be completed by December 31, 2015. Business Office will provide monies to a charge nurse at end of work day with a sign off sheet and upon the next working day, BOM will retrieve balance from charge nurse. 4. How the corrective action will be monitored to ensure the deficeint practice will not recur:Business Office will submit sign off sheet weekly to Executive Director for 4 weeks, then monthly for 5 months. BOM will provide audit tool to QAPI monthly with percentage compliance for review and adjustments will be addressed if applicable to ensure quality improvement.5. Date of Compliance:December 31, 2015</p>	

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F 0242 SS=D Bldg. 00	<p>money in it at the front desk for residents to get money out if they needed to but they had not been doing that lately. She indicated residents were aware they should get a hold of her before 4:00 p.m. on Friday if they needed money for the weekend. She further indicated there was no where she knew of where information was posted for residents to know how to get access to their money after 4:00 p.m. or on the weekends.</p> <p>3.1-6(f)(1)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview, record review and observation, the facility failed to ensure each resident had a choice in regards to bathing for 1 of 3 residents reviewed for choices of the 4 residents who met the criteria for choices. (Resident #67)</p> <p>Finding includes:</p>	F 0242	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 67 was given a shower on 11.17.15. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents who are coded</p>	12/31/2015

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	<p>On 11/10/15 at 11:43 a.m., Resident #67 was interviewed. At that time, the resident indicated she would prefer to take a shower, but has only been given bed baths.</p> <p>The record for Resident #67 was reviewed on 11/13/15 at 8:45 a.m. The resident was re-admitted to the facility on 1/9/15.</p> <p>Review of the "Bathing Type Detail Report" from 10/1/15 through 11/11/15, indicated the resident received partial to full bed baths.</p> <p>The residents last preference sheet for bathing, undated, indicated the resident preferred showers and in the mornings.</p> <p>The residents last Significant Change MDS (Minimum Data Set) assessment was completed on 1/17/15.</p> <p>Review of the revised plan of care dated 1/9/14, indicated the resident preferred showers and in the mornings.</p> <p>On 11/16/15 at 6:30 a.m. the resident was observed receiving a bed bath by CNA #1 and CNA #2. During that observation, the resident was not given a choice on the type of bathing.</p>		<p>on the MDS Section F400c as choices for bathing are somewhat important or very important have the potential to be affected by the alleged deficient practice. Residents were audited to ensure the preference that is care planned matches the bathing schedule. Residents found to be affected had their bathing schedule corrected to match resident's preference. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be educated regarding residents right to have a preference re: bathing. Nursing staff will be educated regarding resident's bathing preference being listed on the bathing schedule. 4 How the corrective action will be monitored to ensure the deficient practice will not recur: Bathing schedule audit will be reviewed weekly by DNS/Designee to ensure that all new admits have been assessed for bathing preferences and bathing schedule updated. Quarterly care plan audit will be completed by IDT with each quarterly/annual MDS to ensure residents bathing preference is being followed. Audits will continue with each of these MDS' for the next 6 months to ensure that the deficient practice does not recur.</p>	

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	<p>Interview with CNA # 1 on 11/13/15 at 9:03 a.m., indicated the resident received a bed bath every day.</p> <p>Interview with the C Wing Unit Manager on 11/13/15 at 9:56 a.m., indicated bathing preferences are discussed with resident with Social Services and the therapy department.</p> <p>Interview with SS #2 and SS #1 on 11/13/15 at 10:12 a.m., indicated bathing preferences are discussed with the residents at the 72 hour (admission) meeting, quarterly with MDS assessments, significant changes and if the resident files a grievance. The Activities Director asks bathing preferences with the quarterly MDS assessments and Social Services follows up at the care plan meetings.</p> <p>Interview with the Activities Director on 11/13/15 at 1:26 p.m., indicated bathing preferences are completed with the initial, annual and significant MDS assessments.</p> <p>Interview with the C Wing Unit Manger on 11/17/15 at 2:52 p.m., indicated a lack of communication with the Activities Director. The Unit Manager further indicated, she did not know the resident preferred a shower.</p>			

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F 0247 SS=A Bldg. 00	<p>Interview with the Activities Director on 11/17/15 at 3:08 p.m., indicated after the completion of the MDS assessment, the bathing preference is updated on the resident's plan of care.</p> <p>Interview with LPN #1 on 11/17/15 at 3:09 p.m., indicated if the resident refused bathing, then it would have been discussed in daily stand up meetings.</p> <p>3.1-3(u)(1)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p>			

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	<p>Based on record review and interview, the facility failed to notify a cognitively impaired resident's responsible party prior to room changes for 1 of 2 residents reviewed for the Admission, Transfer, Discharge of the 2 residents who met the criteria for Admission, Transfer, and Discharge. (Resident #32)</p> <p>Finding includes:</p> <p>Interview with Resident #32's Responsible Party (RP) on 11/9/15 at 2:46 p.m., indicated, "They just moved him one day, they didn't tell me. When I came to visit he was already moved."</p> <p>Review of Resident #32's record on 11/12/15 at 4:12 p.m., indicated the following census room changes: 5/13/15 inpatient room 211-1 6/18/15 hospital leave 6/19/15 return room 213-1 9/11/15 room 205-1 10/22/15 room 215-1</p> <p>Review of the Progress Notes indicated a lack of notification of Resident #32's RP prior to any room change.</p> <p>Interview on 11/13/15 at 9:28 a.m. with SS (Social Services) #1, indicated there should have been documentation in the Progress Notes when family and/or a</p>	F 0247	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #32's POA was notified verbally on 10.21.15 and documented verbal conversation on 11.30.15.</p> <p>2. How other residents having the potential to be affected by the deficient practice will be identified and what correctvie action will be taken: Whole house audit conducted on November 30, 2015 with 3 other residents identified to lack documented notifications. All identified were confirmed and documented on November 30, 2015.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Social Service Director was educated on December 15, 2015 on documentation guidelines regarding room transfers. SS/Designee will audit room move notes weekly for 3 months then every other week for 3 months.</p> <p>4. How the corrective action will be monitored to ensure the deficeint practice will not recur: Social Service Director will provide audit tool to QAPI monthly with percentage compliance for review and adjustments will be addressed if applicable to ensure quality improvement.</p> <p>5. Date of Completion: 12.31.2015</p>	12/31/2015

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F 0279 SS=D Bldg. 00	<p>resident was notified of a room change. There was indication Resident #32's RP was notified of any room changes.</p> <p>Follow up interview with SS #1 on 11/13/15 at 10:15 a.m., indicated SS #2 had talked to the resident's RP regarding the room changes, but did not document it anywhere.</p> <p>3.1-3(v)(2)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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 record review and interview, the facility failed to devise an ADL</p>	F 0279	1. What corrective action will be accomplished for those residents found to have been affected by	12/31/2015

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	<p>(Activities of Daily Living) care plan for a dependent resident for 1 of 30 residents whose care plans were reviewed. (Resident #165)</p> <p>Finding includes:</p> <p>Resident #165's record was reviewed on 11/12/15 at 11:41 a.m. Diagnoses included, but were not limited to, dementia, anuria/oliguria (decreased urine output), joint pain, hypertension, and dehydration.</p> <p>Review of an Admission 5 day MDS (Minimum Data Set) assessment dated 10/2/15 indicated the resident was severely cognitively impaired and was an extensive one person assist for most ADLs.</p> <p>Review of the resident's care plans indicated a lack of a care plan pertaining to ADLs and assistance needed.</p> <p>Interview on 11/13/15 2:28 p.m. with the MDS Coordinator, indicated if a resident were an extensive assist for ADLs, the resident should have had an ADL care plan completed. She further indicated the Admission MDS assessment documented Resident #165 was an extensive assist for most ADLs and indicated he should have had an ADL care plan completed upon</p>		<p>the deficient practice: ADL care plan was created for resident 165 on 11.13.15. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential of being affected by the alleged deficient practice. A whole house care plan audit was completed and any identified as missing or inaccurate were implemented or revised. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: MDS nurses, Unit Managers and nurses will be reeducated regarding implementing care plans for all residents. 4 How the corrective action will be monitored to ensure the deficient practice will not recur: Care plan audit will be completed by MDS with each new admit and quarterly to ensure comprehensive care plans are present. Audits will continue with each of these MDS' for the next 6 months to ensure the deficient practice does not reoccur. Results of the quarterly care plan audit will be reviewed by the DNS monthly to identify any facility trends or patterns Results will be brought to QAPI monthly for 6 months.</p>	

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F 0280 SS=D Bldg. 00	<p>admission.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update and revise care plans related to a pressure ulcer for 1 of 30 residents reviewed for care plans. (Resident #200)</p> <p>Finding includes:</p> <p>The record for Resident #200 was reviewed on 11/12/15 at 10:09 a.m. The</p>	F 0280	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Care plan was revised for resident 200 on 11.19.15. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential of being affected by the</p>	12/31/2015

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	<p>resident's diagnoses included, but were not limited to, hyperlipidemia, hypothyroidism, and heart failure.</p> <p>Review of the 10/14/15 Admission Minimum Data Set (MDS) assessment indicated the resident had two unhealed stage one pressure ulcers.</p> <p>Review of the current care plan, last updated on 10/13/15, indicated the resident was at risk for pressure ulcers due to being admitted to the facility with a reddened area to his vertebra, coccyx and heels.</p> <p>Review a Progress Note, dated 10/22/15 at 2200 (10:00 p.m.) indicated the previous red area to the resident's midthoracic area was observed to be open.</p> <p>Review of a Progress Note, dated 10/23/15 at 1341 indicated the wound to the resident's lumbar area had deteriorated.</p> <p>Review of a Progress Note, dated 10/23/15 at 1601 indicated the resident's wound to his back was unstageable.</p> <p>Interview with the MDS Coordinator on 11/13/15 at 2:41 p.m. indicated the care plan should have been updated to indicate</p>		<p>alleged deficient practice. A whole house care plan audit was completed and any identified as missing or inaccurate were implemented or revised. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Unit managers and nurses will be reeducated regarding updating care plans with any changes in plan of care. 4. How the corrective action will be monitored to ensur the deficient practice will not recur: Care plan audit will be completed by MDS with each new admit and quarterly to ensure comprehensive care plans are present. Audits will continue with each of these MDS' for the next 6 months to ensure the deficient practice does not reoccur. Results of the quarterly care plan audit will be reviewed by the DNS monthly to identify any facility trends or patterns Results will be brought to QAPI monthly for 6 months.</p>	

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F 0282 SS=D Bldg. 00	<p>the resident had an unstageable pressure area. She further indicated with any significant change the care plan should be updated within seven days.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 provide services in accordance with a resident's written plan of care for 1 of 30 residents whose care plans were reviewed. (Resident #165)</p> <p>Finding includes:</p> <p>On 11/12/15 at 10:54 a.m., Resident #165 was observed sitting in his wheelchair at a table in the main unit dining area. His indwelling urinary catheter tubing was observed resting on the ground.</p> <p>On 11/13/15 at 9:03 a.m., Resident #165 was observed sitting in his wheelchair at a table in the main unit dining area. His indwelling urinary catheter tubing was observed resting on the ground.</p>	F 0282	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 165 was discharged on 11.13.15.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All resident's care plans were reviewed and have the potential of being affected. Whole house care plan audit was completed with any missing or inaccurate care plans were implemented and/or revised.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be reeducated on following care plans.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not</p>	12/31/2015

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	<p>Interview with the D Wing Unit Manager (UM) on 11/13/2015 9:09 a.m., indicated urinary catheter tubing should not be on the ground, but should be kept off the floor in the dignity bag and staff are aware.</p> <p>Resident #165's record was reviewed on 11/12/15 at 11:41 a.m. Diagnoses included, but were not limited to, dementia without behaviors, joint pain, history of UTIs (urinary tract infections), gout and hypertension</p> <p>Review of the Admission 5 day MDS (Minimum Data Set) assessment dated 10/2/15 indicated the resident was severely cognitively impaired and required an extensive assist of one person for most ADLs. The resident also had an indwelling catheter.</p> <p>Current orders included: - 18 Fr (size) foley cath (catheter) for dx. (diagnosis of) urinary retention</p> <p>Review of the resident's Care Plans indicated a care plan for "Alteration in elimination of bowel and bladder. Indwelling urinary catheter d/t (due to) enlarged prostate and urinary retention." Interventions included, but were not limited to, change catheter bag; change</p>		<p>recur: Unit managers will audit 2x/weekly for 4 weeks, weekly for 4 weeks then monthly for 4 months to ensure care plans are being followed appropriately. Any updates or revisions to care plans will be added to the CNA assignment sheets 5x/weekly and as needed. Audit will be submitted to DNS for review to identify any facility trends or patterns and to QAPI monthly for 6 months with percentage compliance for review and recommendations.</p>	

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F 0309 SS=D Bldg. 00	<p>foley catheter; check catheter bag; and check catheter tubing for proper drainage and positioning.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to monitor the resident's access site for dialysis for 1 of 1 residents reviewed for dialysis. (Resident #27)</p> <p>Findings include:</p> <p>The record for Resident #27 was reviewed on 11/13/15 at 3:36 p.m. The resident's diagnosis included, but were not limited to, end stage renal disease and dependence on renal dialysis. The resident's re-admission into the facility was on 7/16/15.</p> <p>The Physician Order dated 6/18/15 indicated to monitor the R (Right) arm dialysis fistula (a surgical procedure when an</p>	F 0309	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident affected by the alleged deficient practice had assessment completed. IT department was able to correct the IT issue and Medication Administration Record was verified for documentation.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Other residents receiving dialysis have the potential to be affected by the alleged deficient practice Medication Administration records were reviewed to ensure orders for assessments are in place and documentation of assessments is present. No other residents were</p>	12/31/2015

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	<p>artery and vein are directly connected to cleanse the blood through dialysis) site for positive bruit/thrill (the vibration of blood going through the arm is thrill and the sound is the bruit) and any signs and symptoms of infection or bleeding every shift.</p> <p>Review of the the September MAR (Medication Administration Record), lacked an indications the right arm fistula was monitored from 9/1/15 through 9/12/15.</p> <p>Review of the Dialysis/Observation Communication Forms lacked indication a pre and post dialysis monitoring of the right arm fistula from 9/1/15 through 9/10/15 dialysis appointments.</p> <p>Review of the Nurse Progress notes from 9/3/15 through 9/10/15, indicated a lack of documentation for the monitoring of the right arm fistula.</p> <p>Review of the residents plan of care for end stage renal disease dated 4/29/15, indicated an intervention to check the access site and monitor the thrill and bruit daily.</p> <p>Interview with the C Wing Unit Manager on 11/16/15 at 11:40 a.m., indicated the month of August and the September dates</p>		<p>identified by the alleged deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice des not recur: Nurses and Unit Managers were reeducated to continue placing assessment orders for dialysis residents and ensure documentation is completed. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: New residents receiving dialysis will be audited to ensure assessment orders continue to be implemented. DNS/Designee will print dialysis orders monthly to ensure all residents receiving dialysis continue to have assessments in place and completed. Results of the dialysis audit will be submitted to QAPI with percentage compliance for 6 months for review and recommendations.</p>	

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F 0312 SS=D Bldg. 00	<p>9/1/15 through 9/12/15, had computer problem. The computer X' d out all orders.</p> <p>Interview with the resident on 11/17/15 at 9:32 a.m., indicated not all of the nurses on every shift had checked the fistula.</p> <p>The policy titled, "Dialysis Guideline" was provided by the Administrator on 11/9/15, and indicated, "...Post Dialysis Protocol...Check fistula for bruit (listening to fistula) or feel for a thrill (by touching the fistula.) This must be done daily...."</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to</p>	F 0312	1 What corrective action will be accomplished for those residents found to have been affected by	12/31/2015

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	<p>provide ADL (Activities of Daily Living) care for a dependent resident for 1 of 3 residents reviewed for ADLs of the 66 who met the criteria for ADLs. (Resident #165)</p> <p>Finding includes:</p> <p>On 11/12/15 at 10:54 a.m., Resident #165 was observed sitting in his wheelchair at a table in the main unit dining area. His fingernails were observed to be long and unkempt with dirt underneath.</p> <p>On 11/12/15 at 1:00 p.m., Resident #165 was observed sitting in his wheelchair in the hallway outside the main unit dining area. His fingernails were long and unkempt with dirt underneath.</p> <p>On 11/13/15 at 9:03 a.m., Resident #165 was observed sitting in his wheelchair at a table in the main unit dining area. His fingernails were long and unkempt with dirt underneath.</p> <p>Resident #165's record was reviewed on 11/12/15 at 11:41 a.m. Diagnoses included, but were not limited to, dementia without behaviors, joint pain, history of UTIs (urinary tract infections), gout and hypertension</p> <p>Review of the Admission 5 day MDS</p>		<p>the deficient practice: Resident #165 was discharged on 11.13.15. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. Any resident identified was provided ADL care with updated/revised bathing preferences identified on ADL care plan and bathing schedule. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff reeducated on bathing schedules and preferences. Preferences will be listed on the units bathing schedule in addition to the resident's care plan. Nurses/Manager will be required to sign off on the bathing schedule each day after ensuring that bathing and nail care has occurred. 4 How the corrective action will be monitored to ensure the deficient practice will not recur: Unit Managers will audit the bathing schedule 3x/weekly for 6 months. Audits will be submitted to DNS weekly to identify trends or patterns. Results will be submitted to QAPI monthly for 6 months with percentage compliance for review and recommendations.</p>	

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	<p>(Minimum Data Set) assessment dated 10/2/15 indicated the resident was severely cognitively impaired and required an extensive assist of one person for most ADLs.</p> <p>Review of shower logs for October and November 2015 indicated Resident #165 had received a partial bath on 9/30/15, a shower on 10/3/15, a shower on 10/14/15, a shower on 10/28/15, and a partial bath on 11/11/15</p> <p>The record lacked any documentation to indicate Resident #165 had a preference of infrequent bathing or behaviors of refusal of care.</p> <p>Interview with the D Wing Unit Manager (UM) on 11/13/15 at 9:05 a.m., indicated Resident #165's nails were long and dirty. She further indicated his nails should have been clipped and cleaned with his showers.</p> <p>Follow up interview with the D Wing UM on 11/13/15 at 2:25 p.m., indicated Resident #165 should have had at least two showers a week and showers or refusals if applicable should have been documented in care tracker.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(3)(E)</p>			

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F 0315 SS=D Bldg. 00	<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 with an indwelling urinary catheter received the necessary care and services to prevent a urinary tract infection for 1 of 2 residents reviewed for urinary catheter use of the 2 residents who met the criteria for urinary catheter use. (Resident #165)</p> <p>Finding includes:</p> <p>On 11/12/15 at 10:54 a.m., Resident #165 was observed sitting in his wheelchair at a table in the main unit dining area. His indwelling urinary catheter tubing was observed resting on the ground.</p> <p>On 11/13/15 at 9:03 a.m., Resident #165 was observed sitting in his wheelchair at</p>	F 0315	<p>1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 165 was discharged on 11.13.15.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents with indwelling catheters have the potential of being affected Whole house audit conducted and no other residents were identified as being affected.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be reeducated on appropriate catheter tubing placement.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: Unit managers will audit</p>	12/31/2015

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	<p>a table in the main unit dining area. His indwelling urinary catheter tubing was observed resting on the ground.</p> <p>Interview with the D Wing Unit Manager (UM) on 11/13/2015 9:09 a.m., indicated urinary catheter tubing should not be on the ground, but should be kept off the floor in the dignity bag and staff were aware.</p> <p>Resident #165's record was reviewed on 11/12/15 at 11:41 a.m. Diagnoses included, but were not limited to, dementia without behaviors, joint pain, history of UTIs (urinary tract infections), gout and hypertension</p> <p>Review of the Admission 5 day MDS (Minimum Data Set) assessment dated 10/2/15 indicated the resident was severely cognitively impaired and required an extensive assist of one person for most ADLs. The resident also had an indwelling catheter.</p> <p>Current orders included: - 18 Fr (size) foley cath (catheter) for dx. (diagnosis of) urinary retention</p> <p>Review of the resident's Care Plans indicated a care plan for "Alteration in elimination of bowel and bladder. Indwelling urinary catheter d/t (due to)</p>		2x/weekly for 4 weeks, weekly for 4 weeks then monthly for 4 months to ensure catheter bag positioning is appropriate. Audit will be submitted to DNS for review to identify any facility trends or patterns and to QAPI monthly with percentage compliance for review and recommendations.	

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F 0323 SS=D Bldg. 00	<p>enlarged prostate and urinary retention." Interventions included, but were not limited to, change catheter bag; change foley catheter; check catheter bag; and check catheter tubing for proper drainage and positioning.</p> <p>A policy titled "Incontinence Management/ Bladder Function Guideline" was presented by the DON (Director of Nursing) on 11/17/15 at 2:45 p.m. and deemed as current. The policy included an "Indwelling Catheter Justification/ Decision Diagram" which indicated, "Complete Care Plan for Indwelling Catheter: ... Interventions: ... Check catheter tubing for proper drainage and positioning"</p> <p>3.1-41(a)(2)</p> <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. Based on observation and interview, the facility failed to provide a safe environment free from hazards related to unlocked soiled utility room doors and a</p>	F 0323	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #40's bed control was replaced	12/31/2015

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	<p>frayed electrical bed control pad for 1 of the 40 residents whose rooms were observed. (Resident #40, C-Wing, D-Wing)</p> <p>Findings include:</p> <p>1. Resident #40's room was observed on 11/10/15 at 9:36 a.m. At that time the electrical bed control pad was within the resident's reach and was noted to have exposed frayed wires along the cord.</p> <p>Resident #40's record was reviewed on 11/18/15 at 2:16 p.m. The 9/14/15 Quarterly MDS assessment indicated the resident was cognitively intact and had no limitations to her range of motion.</p> <p>During an interview with the Maintenance Supervisor on 11/10/15 at 9:58 a.m., he indicated he would replace the cord.</p> <p>2. During the initial tour of the facility on 11/9/15 at 9:15 a.m. the soiled utility room doors on C-Wing and D-Wing were observed to be unlocked. The doors had code buttons but were unlocked.</p> <p>During an interview with the Interim Administrator on 11/9/15 at 11:40 a.m. indicated she had heard about the soiled utility doors being unlocked during initial</p>		<p>on November 10, 2015. Soiled Utility doors were modified to prevent unlocking mechanism to function on November 9, 2015.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actgion will be taken: Whole house audit on bed controls were conducted on 12.9.15 and 8 residents had the potential of being affected. Bed cords replaced and/or fixed on 12.9.15. No other Soiled Utility rooms were identified. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff education on bed cords and Soiled Utility rooms to be completed by December 31, 2015. Maintenance Director/Designee will audit bed cords and Soiled Utility Door locks weekly for 4 weeks, then every other week for 4 weeks then monthly for 4 months. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Maintenance Director will provide audit tool to QAPI monthly with percentage compliance for review and adjustments will be addressed if applicable to ensure quality improvement.</p>	

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F 0431 SS=D Bldg. 00	<p>tour. She indicated staff had figured out how to keep the doors unlocked and bypass the code. She further indicated the doors should be locked and maintenance was going to epoxy the door handle so the staff would have to use the code and would no longer be able to fix the knob to stay open.</p> <p>3.1-45(a)(1)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked,</p>			

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	<p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to follow proper medication expiration dates for residents' insulin related to 2 of 13 insulins being expired on 1 of 3 medication carts observed for Medication Storage. (B Wing Lodge 1 cart)</p> <p>Finding includes:</p> <p>On 11/17/15 at 3:32 p.m., the B Wing Lodge 1 cart was checked with RN #1. At the time of the observation, a Levemir (long-acting) insulin flex pen for Resident #145 was observed marked with the open date of 10/1/15 and had been in use for 48 days. A Novolin R (short-acting) insulin vial for Resident #201 was observed marked with the open date of 10/8/15 and had been in use for 41 days. RN #1 was unsure at the time of the observation when each type of insulin expired.</p> <p>Interview with the DON (Director of Nursing) on 11/18/15 at 9:11 a.m. indicated the Levemir insulin should</p>	F 0431	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The expired insulin was removed from the medication cart on 11.17.15. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents receiving insulin have the potential to be affected by the alleged deficient practice. Whole house audit conducted with no other expired medications found. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nurses were reeducated regarding expiration dates and medication storage. 4 How the corrective action will be monitored to ensure the deficient practice will not recur: Unit Managers will audit medication carts weekly for 4 weeks then monthly for 5 months. Audit results will be submitted to DNS to identify any facility trends or patterns. Results will be submitted to QAPI monthly for 6 months with percentage</p>	12/31/2015

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F 0465 SS=E Bldg. 00	<p>have been replaced after 42 days of use and the Novolin R insulin should have been replaced after 28 days of use.</p> <p>Review of professional resource "Nursing 2014 Drug Handbook" page 751, indicated, "Levemir insulin ... after initial use, a cartridge or prefilled syringe may be used for up to 42 days if kept at room temperature"</p> <p>Review of the official manufacturer's instructions for Novolin R insulin indicated, "NovoLog® lasts up to 28 days without refrigeration after first use"</p> <p>3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred walls, discolored pull cords, and stained privacy curtains throughout the facility.</p>	F 0465	<p>compliance for review and recommendations.</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Ceiling light cover replaced on 11.23.15. Room 25 bathroom door cleaned 11.19.15, bathroom floor</p>	12/31/2015

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	<p>(AACU, B Wing, C Wing, D Wing)</p> <p>Findings include:</p> <p>During an environmental tour with the Interim Administrator, Maintenance Supervisor, and the Housekeeping and Laundry Supervisor on 11/19/15 at 9:50 a.m. through 10:40 a.m., the following was observed:</p> <p>1. AACU</p> <p>a. The ceiling light cover outside Room 22 was cracked in the corner.</p> <p>b. Room 25: There was a dried brown substance on the inside of the bathroom door near the door handle. The area behind and underneath the toilet was black. Two residents resided in the room.</p> <p>2. B Wing</p> <p>a. Room 4-1: The closet door was scratched and gouged. The floor tile in front of the closet was cracked. Two residents resided in the room.</p> <p>b. Room 11-2: There were black mars on the floor by the closet and the register vent was rusted. Two residents resided in the room.</p>		<p>cleaned 11.23.15. Room 4 bed-1 closet door replaced on 12.16.15, floor tiles replaced on 12.17.15. Room 11-2 floor completed on 12.7.15. Register vent painted on 11.24.15. Room 17-1 covebase replaced 11.24.15. Ceiling tile outside Rm 210 was replaced on 11.24.15. Rm 212-2 wall and curtain cleaned on 11.24.15. Rm 215 bathroom door and wall repainted on 11.25.15. Rm 216 wall repainted on 11.25.15. Rm 221 cove base replaced on 11.30.15. Rm 224 wall repainted, tile replaced, register vent painted and caulk replaced on 11.30.15. Bathroom floor and privacy curtain cleaned on 11.24.15. Rm 225 wall repainted on 12.1.15, caulk replaced 12.10.15. Rm 226 register vent repainted and hole sealed on 12.1.15. Rm 231 ceiling cleaned on 12.1.15, corner caulk, paper towel dispenser pulley completed 12.9.15. Rm 232 wall patched, floor replaced, and paper towel dispenser completed on 12.3.15, covebase and door knob replaced on 12.9.15. Rm 302 call light cord, covebase and paper towel dispenser completed on 12.3.15. Rm 306 wall repainted, floor tile replaced, vent repainted, call light cord replaced and paper towel dispenser pulley added on 12.9.15. Rm 307 caulk, tile, call light pull cord and covebase completed on 12.3.15. Rm 308 corner bead and pull cord</p>	

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	<p>c. Room 17-1: The cove base in the bathroom was loose from the wall. One resident resided in the room.</p> <p>3. C Wing</p> <p>a. The ceiling tile outside of Room 210 was stained.</p> <p>b. Room 212-2: There were multiple dried brown splatter spots on the wall behind the bed and the privacy curtain was stained. One resident resided in the room.</p> <p>c. Room 215: The inside of the bathroom door and bathroom wall was marred. Two residents resided in the room.</p> <p>d. Room 216-1: The wall near the room entrance was marred and gouged. One resident resided in the room.</p> <p>e. Room 221-2: The cove base behind the room door was loose and coming off the wall. Two residents resided in the room.</p> <p>f. Room 224: The wall behind bed 2 was marred. The floor tile at the end of bed 2 had gaps in it. The register vent was rusted. The floor in the bathroom</p>		<p>replaced on 11.24.15. Rm 310 wall corner, call light pull cord and pulley attached to paper towel dispenser completed on 11.24.15. Rm 312 bathroom floor replaced on 12.16.15 and pulley attached to paper towel dispenser on 11.24.15. Rm 313 call light pull cord, caulk in bathroom, closet knob replaced and pulley attached to paper towel dispenser on 11.24.15. Rm 317 call light cord replaced on 11.24.15. Rm 324 call light cord replaced and rug removed on 11.24.15. Rm 325 walls repainted and call light cord replaced on 11.24.15. Ceiling tile outside Rm 325 replaced on 11.24.15. Rm 329 footboard replaced on 12.7.15 and curtain rehung on 12.4.15. Rm 330 door knob replaced on 12.15.15, curtain replaced on 11.24.15. Rm 332 floor mat removed on 11.24.15 and call light cord replaced on 12.15.15. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Whole house audit completed: 12.11.15 hallway lights and tiles, no others identified. 11.30.15 bathroom floors, 66 rooms identified with all bathrooms completed on 12.10.15. 12.15.15 closet doors and knobs, 12 doors and no knobs identified. 12.15.15 floor tile, 17 tiles</p>	

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	<p>was sticky with non skid strip residue. There was a yellow substance on the caulk behind the sink. The privacy curtain for bed 1 had a brown stain on it. Two residents resided in the room.</p> <p>g. Room 225: The wall behind bed 1 and behind the bed 1 privacy curtain was marred. The bathroom wall was marred and the caulk in the bathroom corner was cracked. Two residents resided in the room.</p> <p>h. Room 226: The register vent was rusted. There was a hole above the cover plate for the bathroom call light pull cord. Two residents resided in the room.</p> <p>i. Room 231: The ceiling near the privacy curtain track of bed 2 was stained. The corner caulk in the bathroom was cracked. The paper towel dispenser in the bathroom was on the wall above the toilet and not at a height easily accessible to the residents. Two residents resided in the room.</p> <p>j. Room 232: The wall by the register vent had cracked plaster. The floor tile by bed 2 was cracked. The outside bathroom door knob was bent. The cove base in the bathroom was loose. The paper towel dispenser in the bathroom was on the wall above the toilet and not</p>		<p>identified.</p> <p>11.30.15 stained closet door flooring, 52 identified. 12.15.15 vents, 29 identified. 12.15.15 covebase, 7 areas identified. 12.15.15 marred walls, 33 areas identified. 11.25.15 privacy curtains, 70 curtains identified. 11.27.15 bathroom caulk, 41 identified. 12.15.15 call light cord, 18 identified. 12.15.15 paper towel dispenser, 70 identified. 12.2.15 curtain rods, 4 identified. 12.15.15 footboard, 5 beds identified. 12.15.15 bathroom door knobs, 40 knobs identified. 12.1.15 nonskid mats, 18 identified. All identified areas to be completed by 12.31.2015</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director and Housekeeping Supervisor educated on room inspection guidelines. Maintenance Director/Designee will audit ceiling tiles, paper towel cords, bathroom call cords, and hallway light covers weekly for 1 month then every other week for 1 month then monthly for 4 months. Maintenance Director/Designee will audit resident room walls, door knobs, vents, floor tile and closet doors monthly for 6 months. Housekeeping Supervisor/Designee will audit resident non-skid mats, privacy and window curtains, bathroom</p>	

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	<p>at a height easily accessible to the residents. Two residents resided in the room.</p> <p>4. D Wing</p> <p>a. Room 302: The bathroom call light pull cord was discolored. The cove base behind the toilet was loose. The paper towel dispenser in the bathroom was on the wall above the toilet and not at a height easily accessible to the residents. Two residents resided in the room.</p> <p>b. Room 306-2: The wall corner near the shelves was gouged. The floor tile by bed 2 and the register vent was cracked. The bathroom call light pull cord was discolored. The paper towel dispenser in the bathroom was on the wall above the toilet and not at a height easily accessible to the residents. Two residents resided in the room.</p> <p>c. Room 307: The caulk and tile in the bathroom corner was cracked. The bathroom call light pull cord was discolored. The cove base in the bathroom was loose. Two residents resided in the room.</p> <p>d. Room 308: The wall corner near the shelves was gouged. The bathroom call light pull cord was discolored. Two</p>		<p>caulk and closet and bathroom flooring weekly for 6 months. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Maintenance Director and Housekeeping Supervisor will provide audit tools to QAPI monthly with percentage compliance for review and adjustments will be addressed if applicable to ensure quality improvement.</p>	

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	<p>residents resided in the room.</p> <p>e. Room 310: The wall corner between bed 1 and the bathroom was gouged. The bathroom call light pull cord was discolored. The paper towel dispenser in the bathroom was on the wall above the toilet and not at a height easily accessible to the residents. Two residents resided in the room.</p> <p>f. Room 312: The bathroom floor was peeling up in the corner by the toilet. The paper towel dispenser in the bathroom was on the wall above the toilet and not at a height easily accessible to the residents. Two residents resided in the room.</p> <p>g. Room 313: The bathroom call light pull cord was missing. The caulk in the corner of the bathroom was cracked. The knob on the closet door was missing. The paper towel dispenser in the bathroom was on the wall above the toilet and not at a height easily accessible to the residents. Two residents resided in the room.</p> <p>h. Room 317: The bathroom call light pull cord was discolored. Two residents resided in the room.</p> <p>i. Room 324: The bathroom call light</p>			

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	<p>pull cord was discolored. The rug in the bathroom had debris on it. Two residents resided in the room.</p> <p>j. Room 325: The wall behind bed 2 was gouged. The wall behind bed 2's dresser was gouged. The bathroom call light pull cord was discolored. Two residents resided in the room.</p> <p>k. The ceiling tile outside of Room 325 had a brown stain.</p> <p>l. Room 329-2: The end of the bed frame of bed 2 was missing a piece. The curtain on above the window was hanging off the track. Two residents resided in the room.</p> <p>m. Room 330: The bathroom door knob was pushed in and bent. The privacy curtain for bed 2 was stained. Two residents resided in the room.</p> <p>n. Room 332: The floor mat by bed 2 had debris on it. The bathroom call light pull cord was discolored. Two residents resided in the room.</p> <p>Interview with the Interim Administrator, Maintenance Supervisor, and Housekeeping and Laundry Supervisor at the time of the tour indicated all the above areas were in need of cleaning or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410		
(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	
	repair. 3.1-19(f)				