

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
--	--

(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: April 9-10, 14-16, 2014</p> <p>Facility number: 000155 Provider number: 155252 AIM number: 100266830</p> <p>Survey team: Denise Schwandner, RN, TC Barbara Fowler, RN Diana Perry, RN Anna Villian, RN Diane Hancock, RN 4/9-4/10/14</p> <p>Census bed type: SNF/NF: 105 Total: 105</p> <p>Census payor type: Medicare: 13 Medicaid: 63 Other: 29 Total: 105</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 21,2014, by Jodi Meyer, RN</p>	F000000	<p><u>Plan of Correction:</u></p> <p><i>Preparation and submission of this Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.</i></p>	
F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate,</p>			

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
--	--

(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>standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 4 residents reviewed for dental assessments, in a sample of 4 who met the criteria for comprehensively assessed on the Minimum Data Set Assessment for dental status. (Resident #99)</p>	F000272	<p>--F272D What corrective actions will be accomplished for those residents found to have been effected by the deficient practice: A corrected MDS was submitted on resident # 99 . --How other residents have the potential to be affected will be identified: MDS coordinators were in serviced on</p>	05/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
--	--

(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
F000312 SS=D	<p>Findings include:</p> <p>On 4/9/14 at 4:41 p.m., Resident #99 was observed to have natural teeth.</p> <p>On 4/14/14 at at 8:41 a.m. the clinical record was reviewed.</p> <p>The annual MDS (Minimum Data Set) Assessment dated 11/19/13 indicated Resident # 99 was edentulous (lacking natural teeth). The care plan indicated, "At risk for dental problems related to: Broken, loose or carious teeth", initiated 11/21/2012.</p> <p>The "Physician's Progress Note" dated 12/2/13 indicated, "resident had been referred to oral surgeon for dental extraction, removed 5 teeth with complications".</p> <p>On 4/15/14 at 10:38 a.m., CNA #2 indicated Resident #99 has her own teeth and oral care is performed every morning.</p> <p>On 4/15/14 at 11: 25 a.m., interviewed MDS Coordinator #1. The MDS Coordinator #1 indicated edentulous is coded on the MDS Assessment if the resident is missing any teeth.</p> <p>3.1-31(d)</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.</p>		<p>4/28/2014 for accurate dental coding on the MDS by the RAI Coordinator for the state of Indiana, Babrara Wheeler. All dental sections on the MDS for annuals, significant changes and new admissions were reviewed for accurate dental coding and corrected MDS was submitted as applicable. --What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DNS/designee will review 4 MDS' per week for annuals, significant changes and new admission for accurate coding X 4 weeks then 4 MDS records for annuals, significant changes and new admission per month X 6 months. --How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place: Results reviewed in QAA monthly X 6 months unless further monitoring is deemed necessary at that time. --Systemic changes will be completed by: May 16th, 2014 Requesting paper compliance for F272 D.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/16/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS				STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630			
(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>Based on observation, interview, and record review, the facility failed to provide bathing and proper dressing to 2 of 4 residents reviewed in a total sample of 40 residents reviewed for ADLs (activities of daily living.) (Resident #56, Resident #46)</p> <p>Findings include:</p> <p>1. During an observation on 4/9/14 at 2:57 p.m., Resident #56 was observed to be sitting in her room in a wheelchair. Resident #56 indicated she was to receive a shower 2 (two) times a week. Resident #56 indicated she did not always receive a shower and did not know what days she was to have a shower.</p> <p>The clinical record of Resident #56 was reviewed on 4/14/14 at 8:00 a.m. Resident #56 had diagnoses including, but not limited to, small bowel transplant, malabsorption, dementia, depressive disorder, anemia. A MDS (Minimum Data Set) assessment, dated 1/30/14, indicated Resident #56 had a BIMS (Brief Interview of Mental Status) assessment score indicating slight cognitive impairment. The MDS further indicated Resident #56 required physical assist of 1 person for bathing and assist of 1 person for personal hygiene and dressing.</p> <p>A care plan, initiated 1/24/14, indicated Resident #56 had a physical functioning deficit related to self care impairment. The care plan indicated Resident #56 was to improve the current level of physical functioning and was to receive nail care prn (as needed).</p>			F000312	<p>--F312D What corrective actions will be accomplished for those residents found to have been effected by the deficient practice: Resident #56 and #46 shower schedule was reviewed with them for their individual preference. #56 nails were trimmed and polish removed from toenails. #56 to have gripper socks on at all times unless otherwise desired by resident. CNA assignment sheets were updated. --How other residents have the potential to be affected will be identified: All other residents were interviewed and their personal preference for shower time/date were updated on the CNA assignment sheets. All fingernails and toenails checked for a need of trimming and completed by staff or referred to the podiatrist. CNA's were in-serviced on 5/7/14 re: offering showers, completing shower sheets, documenting in caretracker and how to address any refusals as well as the need for trimming of toenail and fingernails on shower days to be documented on the shower sheet.</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: DNS or designee will monitor shower sheets and caretracker compliance 5X/wk X 4 weeks, 2X/wk X 4 weeks and monthly X</p>		05/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
--	--

(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>During an interview on 4/14/14 at 3:55 p.m., RN #1 indicated residents received at least 2 showers per week. RN #1 indicated Resident #56 received 2 showers per week.</p> <p>During an observation on 4/15/14 at 10:15 a.m., Resident #56 was observed to be sitting on the commode having her colostomy appliance changed. Resident #56 had ambulated to the bathroom with assist of 1 (one) staff person and her walker. Resident #56 was observed to have no socks or shoes on her feet. Resident #56 indicated her feet were cold. Resident #56 was observed to have chipped nail polish on her toenails. RN #1 ambulated the resident to her bed and gripper socks were applied to her feet. After lying on her bed, Resident #56 covered her feet with a folded towel. Resident #56 indicated her toenails were too long and needed to be clipped.</p> <p>During an interview on 4/15/14 at 8:14 a.m., Resident #56 indicated she did not know what her assigned shower days were.</p> <p>The unit "Shower Schedule," updated on 4/14/14 and obtained from RN #1 on 4/15/14 at 3:20 p.m., indicated Resident #56 was to receive showers on the day shift every Wednesday and Saturday.</p> <p>During an interview on 4/15/14 at 2: 35 p.m., the DoN (Director of Nursing) indicated the CNAs completed shower sheets on each resident when a shower was completed. The ADL Flow Sheet Log, dated 2/9/14 through 4/15/14, indicated Resident #56 received a shower on 2/12/14, 2/19/14, 3/1/14, 3/19/14, 3/26/14, and 4/12/14. The "Resident Shower Sheet/Skin Concern</p>		<p>6. --How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place: Report findings in QA monthly X 6 months unless further monitoring is deemed necessary at that time. - -Systemic changes will be completed by: May 16th, 2014 Requesting paper compliance for F312 D.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
--	--

(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>Documentation," form supplied by the DoN on 4/15/14 at 2:45 p.m., indicated Resident #56 received a shower on 2/5/14, 2/8/14, 2/19/14, and 3/19/14. The documentation indicated Resident #56 did not have her fingers or toes clipped. The DoN indicated the CNAs are responsible to fill out the form whenever a resident received a shower. The DoN indicated she did not have any other documentation for Resident #56's shower.</p> <p>During and interview on 4/16/14 at 2:24 p.m., CNA #1 indicated showers are scheduled for the residents. CNA #1 further indicated residents are assigned 2 showers per week but some residents received 3 showers per week as they preferred.</p> <p>2. During an interview on 4/9/14 at 2:15 p.m., Resident #46 indicated showers were scheduled 2 times per week. Resident #46 indicated her shower days were Tuesday and Thursday. Resident #46 indicated the shower is given only when the staff had time to give it to her.</p> <p>The clinical record of Resident #46 was reviewed on 4/14/14 at 2:10 p.m. Resident #46 had diagnoses including, but not limited to, depressive disorder, restless leg syndrome, anemia, osteoarthritis, and hypertension. The MDS (Minimum Data Set) assessment indicated the resident had mild cognitive impairment.</p> <p>The CNA (certified nursing assistant) assignment sheet, obtained 4/15/14 at 10:10 a.m., from LPN #2, indicated Resident #46 received a shower on Tuesday and Friday evenings.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/16/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS				STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630			
(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			
F000364 SS=D	<p>During an interview on 4/15/14 at 1:55 p.m., LPN #1 indicated the residents usually received showers 2 times per week.</p> <p>The "ADL (activities of daily living) Flow Sheet," dated 2/14/14 through 4/14/14, indicated Resident #46 received a shower on 2/18/14, 2/25/14, 2/28/14, 3/4/14, 3/14/14, 3/18/14, 3/25/14, 3/28/14, 4/4/14, 4/8/14, and 4/11/14.</p> <p>The "Resident Shower Sheet/Skin Concern Documentation," form supplied by the DoN on 4/15/14 at 2:35 p.m., indicated Resident #46 received a shower on 3/25/14, 3/28/14, 4/1/14, 4/4/14, 4/8/14, and 4/11/14.</p> <p>A policy titled, "Bath (Shower)" obtained from the DoN on 4/16/14 at 2:35 p.m., indicated frequency of documentation should follow the facility policy.</p> <p>3.1-38(a)(2)(A) 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food served was palatable and served at the proper temperature for 2 of 8 residents reviewed in a total sample of 23 that met the criteria for food quality, in that, 2 residents complained of cold food. (Resident #151, Resident #156)</p>	F000364	--F364D What corrective actions will be accomplished for those residents found to have been effected by the deficient practice: No resident #156 or #151 found in sample. DSM provided education with the dining services staff on duty on maintaining serving temperatures and nursing staff on offering residents to reheat their food if	05/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/16/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS				STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630			
(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>Findings include:</p> <p>1. On 4/9/14 at 3:52 p.m., during confidential interview, Resident #151 indicated the food was not tasteful. Resident #151 further indicated the food was "sometimes cold".</p> <p>On 4/10/14 at 2:30 p.m., Resident #151's clinical record was reviewed. Resident #151's most recent MDS (Minimum Data Set) Assessment, dated 2/20/14, indicated Resident # 151's BIMS (Brief Interview for Mental Status) score of 10/15, indicating moderate cognitive impairment.</p> <p>On 4/14/14 at 1:17 p.m., Resident #151 indicated lunch was "not very good". Resident #151 further indicated lunch was served with some type of gravy on top which she did not like it.</p> <p>2. On 4/11/14 at 11:55 a.m., during confidential interview, Resident #156 indicated she had not finished her lunch because it was cold. Resident #156 further indicated she always ate in her room.</p> <p>On 4/14/14 at 8:00 a.m., Resident #156 clinical record was reviewed. Resident #156 had diagnoses including, but not limited to, small bowel transplant and malabsorption. A MDS assessment, dated 1/30/14, indicated Resident #156 had a BIMS which indicated slight cognitive impairment.</p> <p>On 4/14/14 at 8:23 a.m., Resident #156 indicated her breakfast was cold.</p> <p>On 4/15/14 at 8:14 a.m., Resident #156 indicated her breakfast was cold. The breakfast tray was observed to be uneaten.</p>		<p>the resident desired. --How other residents have the potential to be affected will be identified: In service given to nursing and dining staff by 5/7/14 on maintaining food temperatures, and offering to reheat residents food if it is not at a desired temperature. --What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Test tray evaluations will be completed by the DSM/designee one meal per day, 4 days per week for four weeks, then one meal per day 2 days per week for an additional four weeks, and then one meal per week for an additional four weeks (total 12 weeks of monitoring). Each test tray evaluation will include temperatures of the food items for room service as well as interviewing a minimum of 3 residents for appropriate food temperatures. The Registered Dietitian will review test tray evaluations during her visits. DSM/designee will discuss food temperatures at the Food Committee meeting or Resident Council meeting monthly for 6 months. --How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place: The DSM will monitor findings and trends with QAPI on a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
--	--

(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
F000465 SS=E	<p>On 4/16/14 at 2:15 p.m., the Administrator provided the "Food Committee Meeting Minutes". The minutes dated 3/3/14 indicated, "weekends-oatmeal, eggs and soup cold at times".</p> <p>3.1-21(a)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to provide a functional, safe and comfortable environment for residents in 8 of 40 rooms observed in stage 1, in that heater grates were rusty, dusty and contained debris, a bathroom door knob was bent, a hole was in a bathroom door, floor tile was chipped, a crack was in a floor which raised the flooring the length of the room, loose cove base, and wax was built up on floors. (Rooms #106, #108, # 208 , #210, #211, #215, #403 and #405)</p> <p>Finding include:</p> <p>1. Room #106 was observed on 4/9/14 at 2:32 p.m. The heater grate was dirty and rusty. Debris and small white objects were in the grate.</p> <p>2. Room #108 was observed on 4/9/14 at 11:51 a.m.. The heater grate was dirty and</p>	F000465	<p>monthly basis for 6 months unless further monitoring is deemed necessary at that time. - -Systemic changes will be completed by: May 16th, 2014 Requesting paper compliance for F364 D. We are requesting to IDR tag #364 D due to the fact that resident #151 and resident #156 do not exist in our sample of residents.</p> <p>--F465E What corrective actions will be accomplished for those residents found to have been effected by the deficient practice: All heater grates were cleaned of debris and repainted. Room # 208 hole in the door was repaired. Room # 210 cove base was replaced and caulking behind the sink was replaced. Room # 211 chipped tile was replaced. Room # 403 bent door knob was replaced. Room # 405 bathroom entrance with wax buildup was corrected and raised crack in floor repaired. --How other residents have the potential to be affected will be identified: Heater grates in all resident rooms were cleaned of debris and repainted as needed. All bathroom doors were checked for holes and bent door knobs. Cove base observed for cracks, tile for chips and wax buildup. All</p>	05/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/16/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS				STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630			
(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>rusty.</p> <p>3. Room #208 was observed on 4/9/14 at 2:34 p.m. A large hole was observed in the bathroom door .</p> <p>4. Room #210 was observed on 4/4/9/14 ar 2:28 p.m. The heater grate was dirty. There was also chipped tile on floor. The cove base was cracked on the outside wall near bed. The caulking was cracked behind the sink.</p> <p>5. Room #211 was observed on 4/9/14 at 2:30 p.m. The heater grate was dirty and rusty and chipped tile was noted on the floor.</p> <p>6. Room #215 was observed on 4/9/14 at 2:25 p.m. The heater grate was rusty.</p> <p>7. Room #403 was observed on 4/9/14 at 2:23 p.m.. The heater grate was dirty with debris. The bathroom door knob was bent.</p> <p>8. Room #405 was observed on 4/9/14 at 8:44 a.m. The tile on the floor in bathroom entrance had wax build-up and dirty grout in bathroom and room. The floor had a raised crack the length of the bedroom. The heater grate was dirty.</p> <p>On 4/15/14 the above rooms were rechecked and remained unchanged.</p> <p>On 4/15/14 at 2:00 p.m., Housekeeper #1 was interviewed and she indicated that maintainence is responsible for keeping heater units clean. She also indicated the floors are deep cleaned every three months.</p> <p>On 4/16/14 at 9:30 a.m., the DoN (Director of Nursing) was interviewed and indicated that 5-6 heater units were being replaced per</p>		<p>findings repaired as needed. -</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: All heater grates were placed on a preventative maintenance program for cleaning and need for painting monthly. Guardian Angel staff will observe rooms for any chipped tile, wax build up, cracked cove base or flooring and report each morning on the inspection sheet for repair. Maintenance will review findings and repair as needed and report to executive director. Executive Director or designee will monitor inspection round sheets 5 days per week x 4 weeks and then 2x/weekly. --How the corrective action will be monitored to ensure the deficient practice will not recur, what QA program will be put into place: Findings will be reported in QAPI monthly X 6 months unless further monitoring is deemed necessary at that time. --Systemic changes will be completed by: May 16th, 2014We are requesting paper compliance for F465E.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
--	--

(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>year.</p> <p>On 4/16/14 at 2:57 p.m., the policies for deep cleaning of floors and preventative maintenance cleansing of floors was received from the Administrator.</p> <p>3.1-19(f)</p>			