

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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F000000	<p>This visit was for the Certification and State Licensure Survey. This visit included the Investigation of Complaints #IN00138396 and #IN00138613.</p> <p>Complaint #IN00138396 - Substantiated. Federal/state deficiencies related to the allegations are cited at F425, F323, and F364.</p> <p>Complaint #IN00138613 - Substantiated. Federal/state deficiencies related to the allegations are cited at F425 and F323.</p> <p>Survey dates: October 30, 31, November 1, 4, 5, 6, 7, and 8, 2013</p> <p>Facility number: 000039 Provider number: 155685 AIM number: 100275130</p> <p>Survey team: Julie Wagoner, RN, TC Deb Kammeyer, RN Lora Swanson, RN Sharon Ewing, RN (November 4, 5, 6, 7, and 8, 2013)</p> <p>Census bed type: SNF/NF: 153</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.

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	<p>Total: 153</p> <p>Census payor type: Medicare: 15 Medicaid: 116 Other: 22 Total: 153</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 18, 2013, by Janelyn Kulik, RN.</p>			

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F000156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on observations and interviews the facility failed to ensure pertinent advocacy group and contact information was displayed in an easily readable format and location for 2 of 2 residents. (Resident #179 and Resident #44)</p> <p>Findings include:</p> <p>During an interview on 11-5-13 at 10:56 A.M., Resident Council President (Resident #179) indicated she had no idea who or what an ombudsman was nor where to find their phone number. Resident #179 further indicated she didn't know where the Indiana State Health Department's (ISDH) phone number was located at to file a concern.</p> <p>On 11-5-13 at 11:10 A.M., the resident council president was taken to the Garden Dining Area to observe a picture frame (8 1/2 x11) that included the Ombudsman information. The resident was sitting in her wheelchair and was unable to read the information. She also indicated that she had no idea the information was located on that wall.</p> <p>During an interview on 11-8-13 at</p>	F000156	F-156 1. Resident #179 had no adverse outcomes related to the alleged deficient practice and has been informed of the location of the advocacy groups and what the numbers for contacting the agencies. Resident #44 was not identified in the resident sample provided by the surveyors. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Residents of the resident council committee have been informed by the Executive Director of location of bulletin boards and how to contact the advocacy groups.* Facility staff will be in-serviced on this requirement by 12-8-13.4. Executive Director and/or designee will complete weekly rounds for 4 weeks and then monthly thereafter to ensure postings are current and properly placed though out the facility. Audit forms will be completed at the time of rounds with the results of the postings being forwarded to the QA& A committee monthly for 6-months and then the QA&A committee will determine the need for additional auditing.5. Date of Completion 12/8/13	12/08/2013			

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	<p>9:20 A.M., Employee #12 who attended the Resident Council Meeting indicated she was not aware that the Council President did not know where to locate the Ombudsman's name and phone number. She further indicated that each hallway had a bulletin board with that information on it.</p> <p>During an interview on 11-8-13 at 9:30 A.M., Resident #44 who lives on the Southwest Unit, indicated she had no idea where to locate the phone number of ISDH or the Ombudsman.</p> <p>On 11-8-13 at 9:30 A.M., observations were made of the bulletin boards on Primrose, Southwest, East and Dementia Units. Each unit had the ISDH and the Ombudsman's phone numbers on the bulletin board, except the Dementia Unit.</p> <p>During an interview on 11-8-13 at 10:00 A.M., the DON (Director of Nursing) indicated that all units have a bulletin board with Ombudsman and ISDH information. She further indicated the Gardens Dining Area wall had all information in question. The DON went to dining room where those numbers were located on a wall. When asked about the font and</p>				

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	<p>height of the frame she agreed information displayed would be hard to read from a wheelchair. She further indicated she wasn't aware that the Resident Council President could not locate the information.</p> <p>3.1-4(j)(3)</p>			

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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, record review, and interviews, the facility failed to ensure the care plan to prevent pressure ulcers was followed for 1 of 3 residents reviewed for pressure ulcers. (Resident #76)</p> <p>Finding includes:</p> <p>The clinical record for Resident #76 was reviewed on 11/05/13 at 11:36 A.M. Resident #76 was admitted to the facility on 10/04/13 with diagnosis, including but not limited to, dementia, coronary arteriosclerosis, anemia, subacute dyskinesia, altered mental status, post surgical bypass, morbid obesity, malaise and fatigue, and hypertension.</p> <p>The initial MDS (Minimum Data Set) assessment, completed on 10/11/13, indicated the resident had no pressure ulcers but was at risk for pressure ulcers.</p> <p>A nursing progress note, dated 10/07/13, indicated the following: "resident admitted to facility with</p>	F000282	<p>F- 282 1. Resident #76 had no adverse outcomes related to the alleged deficient practice. Resident 76 has had the care plan reviewed and updated to include appropriate interventions/approaches to maintain skin integrity. 2. Residents' residing at the facility have the potential to be affected by the alleged deficient practice. * Residents admitted to the facility will have skin assessments completed to ensure residents at risk for pressure sores have appropriate care plans in place. 3. Facility staff was in-serviced by 12/8/13 by the Director of Clinical Education on the policy of skin assessments and care planning*Residents deemed at risk for pressure sores will have their care plans reviewed and updated if applicable. 4. Care plan audit tools will be audited by the Director of Nursing monthly for 6 months. The results of these audits will be reported by the Director of Nursing to the QAA team monthly for 6 months and then the QAA team will determine the need for additional auditing until a threshold of 100% is achieved. 5. Date of Compliance 12/8/13</p>	12/08/2013	

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	<p>stage II area to left ischium measured 2.2 cm (centimeters) x 0.3 cm x 0.1 cm and stage II area to right ischium measures 2.5 x 2.1 cm, with stage II area to right ischium measures 2.5cm., there is no drainage from either area. Current treatment is calazime (a house barrier cream to prevent skin breakdown) will continue to monitor."</p> <p>On 10/30/13, a physician's order was received for granulex aerosol solution to outer left heel topically every shift to fluid filled blister on outer left heel and mepilex border to open areas on left and right buttocks q (every) day and as needed.</p> <p>A care plan, noted in the electronic clinical record, initiated on 10/05/13, and copies received on 11/06/13, indicated the resident was admitted with multiple bruises and open areas. The goal was for the open areas to be resolved in 30 day. The interventions included: Apply barrier cream as ordered, assist resident with transfers to prevent injury to self, monitor skin condition weekly and prn (as needed), and pressure reducing mattress to bed. Review of the care plan, on 11/07/13 at 11:00 A.M., indicated additional interventions had been handwritten on the care plan but</p>			

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	<p>were not dated. The additional interventions were Mepilex border to open area, granulex to heel as ordered, and moon boots on when in bed. Interview with LPN #25, on 11/07/13 at 11:00 A.M. indicated she thought the additional interventions were added to the care plan on 10/30/13.</p> <p>Resident #76 was observed, on 10/31/13 at 2:43 P.M., lying in his bed awake. The resident was noted to have non-slip socks on both feet and his right foot was noted to be up against the footboard of the bed.</p> <p>Resident #76 was observed, on 11/04/13 at 2:55 P.M., lying in his bed awake. Non-skid socks, cut at the ankles, were noted on the resident's feet. His heels were not floated and there was no air mattress on his bed.</p> <p>On 11/05/13 at 10:30 A.M., Resident #76 was observed lying in his bed on his back. There were blue quilted booties on both his feet. Resident #76's wife was in the room and indicated sometimes in the evenings she had noticed staff putting blue booties on the resident but not always.</p> <p>On 11/05/13 at 10:47 A.M., Resident</p>						

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	#76's left heel was observed. There was a large silver dollar sized fluid filled blister on the bottom outer edge of left heel. 3.1-35(g)(2)				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure treatment for pressure ulcers was timely obtained for 1 of 3 residents reviewed for pressure ulcers. (Resident #76)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #76 was reviewed on 11/05/13 at 11:36 A.M. Resident #76 was admitted to the facility on 10/04/13 with diagnosis, including but not limited to, dementia, coronary arteriosclerosis, anemia, subacute dyskinesia, altered mental status, post surgical bypass, morbid obesity, malaise and fatigue, hypertension.</p> <p>The admission assessment, labeled "Clinical Health Status" form, dated 10/04/13 at 4:00 P.M., indicated a 2.2</p>	F000314	F-3141. Resident #76 suffered no adverse outcomes related to the alleged deficient practice. Resident #76 has been seen by the Medical Director on 11/7/13 and deemed his area unavoidable. The treatment was obtained timely as evidence of the medication administration record. The documentation of this treatment was not accepted by the survey team at the time of exit. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.* Residents admitted to the facility will have their skin assessed and appropriate treatments will be obtained by the residents primary care physician if indicated. 3. Licensed Nurses, Certified Nursing Assistants and the interdisciplinary team will be re-educated on the skin assessment policy as it relates to treatment orders by 12/8/13*Quarterly reviews and newly admitted residents will have	12/08/2013			

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	<p>cm by 0.3 cm open area was noted on the right upper buttock and a 2.5 cm by 0.2 cm open area was noted on the left upper buttock, and an unmeasured area below the diagramed open areas noted as "excoriation."</p> <p>A nursing progress note, dated 10/07/13, indicated the following: "resident admitted to facility with stage II area to left ischium measures 2.2 cm x 0.3 cm x 0.1 cm and stage II area to right ischium measures 2.5 cm x 2.0. cm, with stage II area to right ischium measures 2.5 cm, there is no drainage from either area. Current treatment is calazime will continue to monitor."</p> <p>The admission orders for Resident #76, dated 10/04/13, did not contain any type of treatment for the resident's open areas.</p> <p>A physician's order was obtained on 10/06/13 for calazime skin protectant paste to buttocks topically every shift for incontinence. Interview with LPN #25, unit manager indicated the paste was the "house" cream used as a preventative measure for incontinent residents. There was no documentation the physician</p>		<p>their Skin assessments reviewed by nursing administration for accuracy. 4. Skin assessments will be audited by the Director of Nursing and/or designee. The results of these audits will be reported to the QAA committee monthly for 6 months then the QAA team will determine the need for additional auditing until a threshold of 100% is achieved. Date of compliance: 12/8/13</p>	

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	<p>assigned to the resident upon his admission to the facility was made aware of the open areas and the need for treatment. LPN #25 indicated the physician usually came and examined new residents within a week of admission. There was no documentation provided to indicate the physician was made aware of the open areas, nor was the date of the exam provided.</p> <p>Review of the wound evaluation forms indicated on 10/11/13 the open areas were healed but, right and left buttock remained red and excoriated. The 10/31/13 assessment indicated there were "several small open areas" and the area measured 3.4 cm by 3.0 cm by 0.1 cm. on the right buttock and 2.9 cm by 1.9 cm by 0.1 cm on the left buttock.</p> <p>A physician's order was obtained on 10/30/13 for: " mepilex border to open areas on left and right buttocks q (every) day and prn."</p> <p>The open areas for Resident #76 were observed on 11/05/13 at 10:47 A.M. Resident #76 had a large golf ball sized purplish discolored area on each buttocks. There was a 1 inch half moon shaped stage11 open area on the lower right side and several</p>			

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	<p>superficial open areas within the left side.</p> <p>The Director of Nursing indicated on 11/08/13 during the exit conference that the resident was not admitted with open areas but with "excoriation" and the calazime cream was the treatment for the excoriation and was documented as having been applied starting on 10/06/13. There was no further documentation provided to determine the physician was aware of the open areas and intended the barrier cream as the treatment for the open areas.</p> <p>3.1-48(a)(2)</p>				

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517			
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F000323 SS=D	<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, record review, and interviews, the facility failed to ensure adequate supervision and interventions were implemented to prevent falls for 1 of 3 residents reviewed for falls. (Resident #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #C was reviewed on 11/04/13 at 3:08 P.M. Resident C was admitted to the facility on 10/12/11 with diagnosis, including but not limited to: psychosis, alzheimer's disease, hypertension, epilepsy, esophageal reflux, hyperlipidemia, depressive disorder.</p> <p>Interview with Unit Manager, LPN #26, on 11/01/13 at 9:36 A.M., indicated Resident #C had fallen twice in the past 30 days.</p> <p>Review of the falls for Resident C for the past 4 months indicated she had fallen 10 times. Nine of the 10 falls were noted to have been in her room or her bathroom. Documentation</p>	F000323	F-3231. Resident C was not identified to facility staff due to the nature of the complaint allegation. There were no other residents directly affected by the alleged deficient practice. Residents deemed at risk for falls will have appropriate fall interventions put in place. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. * Residents admitted to the facility will be assessed for falls and appropriate fall interventions will be put into place. 3. Facility staff will be in-serviced by the Director of Clinical Education on supervision to prevent accidents by 12/8/13.* Nursing Administration will be in-serviced on implementation of accident interventions by the Executive Director by 12/8/13 4. Fall analysis audits will be performed by Nursing Administration. The results of these audits will be reported by the Assistant Director of Nursing or designee to the QAA committee monthly for 6 months and then the QAA committee will determine the need for additional auditing until a threshold of 100% is achieved. 5 Date of	12/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
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	<p>regarding each fall and the fall review documentation was provided.</p> <p>On 07/13/13 at 12:42 A.M., the resident fell by her bed trying to transfer herself. The interventions already in place at the time of the fall were: call light and personal items in reach, footwear to prevent slipping, keep environment well lit and free of clutter, observe for side effects of meds, education on calling for assistance with transfers, keep shoes or non-slip socks near bedside, gripper strips next to bed, toilet and grab bar in bathroom, transfer pole in bathroom, assistance as needed to bathroom as she will allow, brake extenders on wheelchair. The documentation indicated she was in a new wheelchair so auto rear locking brakes were to be placed on her wheelchair.</p> <p>On 08/15/13 at 19:00 (7:00 P.M.), Resident C fell while ambulating to the bathroom by herself. On 08/16/13 at 7:30 P.M., Resident C fell in her bathroom where she was unassisted. The 08/19/13 IDT (interdisciplinary team) note indicated there was urine on the floor. The only new intervention added was to "continue educating resident to ask for staff assist when toileting."</p>		Compliance: 12/8/13				

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	<p>On 08/23/13 at 14:34 (2:34 P.M.), Resident C fell in her room and was found beside her bed. The 08/26/13 IDT note indicated only one side of her wheelchair brakes were locked. The new intervention was to place new auto rear locking brakes to her wheelchair. This was the same intervention mentioned on the IDT note after the 07/13/13 fall.</p> <p>On 09/19/13 at 18:30 (6:30 P.M.) Resident C was ambulating with a walker in the dining room and fell. The new intervention was for the resident to utilize a wheelchair as her primary mode of transportation. There was no indication staff was supervising her when she was ambulating with the walker.</p> <p>On 10/02/13 at 21:45 (7:45 P.M.) Resident C was found on the floor in her room beside her bed after having attempted to transfer herself. The 10/03/13 IDT note indicated a new intervention was to place a transfer pole beside her bed to assist her with transfers.</p> <p>On 10/06/13 at 1:42 A.M., Resident C was found on the floor in her bathroom. The 10/07/13 IDT note indicated the resident was being</p>						

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY AVE ELKHART, IN 46517
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	<p>treated for a urinary tract infection and a new intervention to place a bedside commode beside the resident's bed was initiate.</p> <p>On 10/09/13 at 5:55 A.M., Resident C fell while ambulating unassisted in her darkened room. She fell by her roommates bed as she was trying to go to the bathroom. The 10/09/13 IDT note indicated a night light would be placed in the resident's room. There was already an intervention to ensure the environment was well lit in place.</p> <p>On 11/01/13 at 21:00 (9:00 P.M.) and on 11/03/13 at 20:19 (8:19 P.M.) Resident C was found on the floor in her room and bathroom while attempting to toilet herself unassisted. The IDT team notes on 11/04/13 at 10:24 A.M. and 10:40 A.M. indicated the resident was to be toileted after meals and before bedtime and also therapy was to evaluate the resident for a urinary incontinence program.</p> <p>Resident #C was observed on 11/04/13 at 3:00 P.M., seated in her room in a wheelchair. No alarm was noted on her wheelchair. There were nonskid strips and a transfer pole beside her bed.</p>			

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	<p>Resident #C was observed on 11/05/13 at 9:30 A.M. in her room in her wheelchair. The room was dark. The resident had her dentures out and lying on her bed She was noted to be propelling her own wheelchair in her room, no alarm noted to wheelchair.</p> <p>Resident #C was observed on 11/05/13 at 3:10 P.M., seated in her wheelchair in her darkened room asleep. Resident #C woke up and said she was going to bed. No staff were in the room or noted close by in the hallway outside of Resident C's room. There was a music activity on the unit lounge.</p> <p>Resident #C was observed on 11/06/13 at 9:30 A.M., in her wheelchair, scooted 1/2 way towards the front of the wheelchair. The room was dark. The resident was bent over at the waist picking up an empty salt shaker. Her gown was 1/2 unzipped in the front and she had one tube type sock on her right foot and her left foot was bare. The resident did follow advice to scoot herself back in the wheelchair, but only after she had finished picking up the salt shaker.</p> <p>The current care plan related to falls, which had been updated on 09/14/13,</p>						

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	<p>indicated the following: At risk for falls related to use of narcotics and psychotropic medication, seizures, incontinence, requiring assist with ADL (Activities of Daily Living) tasks and dementia. The interventions included: call light or personal items available or in easy reach, footwear to prevent slipping, gripper strips next to bed and in front of toilet, transfer pole by bed and toilet, brake extenders to w/c and auto locking rear brakes, transfer assist if allows, continue to reeducate and remind to call for help when toileting and transferring, keep environment well lit and free of clutter, keep shoes or non-slip socks near bedside, observed for pain, observe for side effects of medications.</p> <p>Although the IDT team had met after each fall, the new interventions on 2 of 10 falls should have already been in place. There was no plan to evaluate a toileting plan until after the resident fell for the fifth time while attempting to toilet herself. There was no intervention put in place to increase supervision and/or alert staff to Resident C's self transfer attempts.</p> <p>This Federal tag relates to Complaint #IN00138396 and In00138613.</p> <p>3.1-45(a)(2)</p>						

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY AVE ELKHART, IN 46517
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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a gradual dose reduction was attempted for 2 of 5 residents reviewed for medications. (Resident C and Resident #166)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #C was reviewed on 11/04/13 at 3:08 P.M. Resident C was admitted to the facility on 10/12/11 with diagnosis,</p>	F000329	F-3291. Resident #166 has had her anti-psychotic medication clarified with the physician and the gradual dose reduction was accepted at the time of the clarification. Resident's plan of care has been updated to reflect the use of this medication. Resident 166 did not suffer any adverse outcomes related to the alleged deficient practice. Resident C was not identified in the survey sample.2. Residents with anti-psychotic medications have the potential to be affected by the alleged deficient practice. *	12/08/2013			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517		
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	<p>including but not limited to: psychosis, alzheimer's disease, hypertension, epilepsy, esophageal reflux, hyperlipidemia, and depressive disorder.</p> <p>The resident had received the antipsychotic medication, Risperdal 0.125 mg (milligrams) at noon and at bedtime since 07/18/12 for "unspecified psychosis." The resident's medical symptom tracked in respect to the medication was agitation and uncooperative/refusing care.</p> <p>The resident also had received the antidepressants, Wellbutrin 150 mg once a day since 09/13/13 for "unspecified psychosis" and Citalopram Hydrobromide 20 mg at bedtime since 10/26/11 for depressive disorder. On 11/04/13, the resident was placed on Cymbalta 60 mg at bedtime for depressive disorder. However, interview with the Director of Nursing, on 11/08/13 at 9:10 A.M. indicated the Cymbalta was actually ordered to address pain issues, not depression.</p> <p>The care plans related to antidepressant and antipsychotic medications, current through 11/27/13 included the following: On</p>		<p>Residents who receive Anti-psychotic medications have been reviewed and care plans modified if appropriate. Residents who are in need of a gradual dose will be forwarded to the attending physician for review and follow up. 3. Licensed Nursing Staff and the Interdisciplinary team will be re-educated by the Director of Clinical Education by 12/8/13 on Anti-psychotic medications and the gradual dose reduction process. 4. Social Service Director's will complete Anti-Psychotic medication audits. The results of those audits will be reported by the Social Services staff monthly for 6 months and then the QAA committee will determine the need for additional auditing until a threshold of 100% is achieved.</p>		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY AVE ELKHART, IN 46517		
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	<p>antidepressant medication due to diagnosis of depressive disorder, as well as displaying periods of tearfulness and agitation. Risperdal for a diagnosis of unspecified psychosis. - will be easily redirected - interventions: if I appear down talk to me and see if there is anything you can do for me, observe for pain, monthly pharmacy reviews, observe for side effects (listed specific side effects for antidepressants and antipsychotics), provide medications, psychotropic medication risk/benefit and reduction plan as recommended by physician and pharmacist. There was also a plan initiated on 03/26/12 regarding the resident exposing her breast and then becoming tearful and agitated. There was a plan regarding the resident becoming sad and tearful about her son refusing to visit her. There was a plan regarding the resident's elopement risk. Finally, there was a plan regarding the resident's long history of "throwing fits and tantrums." Behaviors included in the plan were yelling, screaming, throwing herself on the floor, cursing, making impulsive movements and decisions.</p> <p>Review of the behavior tracking for August 2013 and September 2013 indicated the resident had one</p>				

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	<p>episode of yelling at her roommate in August, which was redirected successfully. One episode of refusing medication in August and 4 episodes of refusing medications in September which were not successfully redirected however the only intervention listed was "attempted x 3." There was no behavior documentation provided for October 2013. The November 2013 documentation for Resident #C indicated "agitated" and "uncooperative/refusal of care" were being monitored. There was one documented episode of both agitated and refusal of care documented. The only interventions attempted were 1:1 and redirection and they were unsuccessful.</p> <p>Review of the pharmacy reports for Resident #C from October 2012 - October 2013 indicated he recommended a Gradual dose reduction on 7 occasions for either the Celexa medication or the Risperdal.</p> <p>On 02/13/13, Resident #C was seen by the facility's psychiatrist at the time. Although the note indicated "No behaviors," and indicated a reduction in attention seeking and agitation, the psychiatrist indicated he would</p>						

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517		
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	<p>evaluate a reduction in the Risperdal in 3 - 6 months and marked a typed comment which read: "I have reviewed the patient's history, medications, response, and possible side effects. Medications are well tolerated and the patient is likely to be negatively impacted should the current medications be changed. There are no clinical indications to reduce psychiatric medications at this time.</p> <p>During an interview, on 11/06/13 at 2:05 P.M, . with the Administrator and SSD employee #28, indicated in June of 2013, (physician's name) who was our psychiatric provider, was abruptly terminated at (hospital name). He had called the facility and told them he was trying to establish his own private practice so he could continue treating residents here. We waited 30 - 60 days and he never came forth with provider number, etc. In September of 2013, Administrator met with IDT and signed contract with (name of psychiatric group) The new psychiatric group had to hire additional staff to service our type of building. They began providing psychiatric services the middle part of October 2013. The facility was aware there were residents due for GDR (gradual dose reductions) but the</p>				

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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	<p>resident's primary care physician's would not address psychiatric medications. The Administrator indicated she was also going to ask the medical director to address some of the reduction but she was not confident he would comply.</p> <p>2. Resident # 166's record was reviewed on 11/4/13 at 2:50 p.m. The resident's diagnoses included, but were not limited to, alzheimer's disease, dementia with behavioral disturbances and depressive disorder not elsewhere classified.</p> <p>The Quarterly Minimum Data Set Assessment, dated 10/10/13, indicated the resident had a Brief Interview for Mental Status score of 03 which indicated severe cognitive impairment. She had a mood severity score of 00. She was coded for feeling tired or having little energy with the frequency of never or 1 day of the assessment period.</p> <p>A Careplan, date initiated 3/25/13 and updated 10/15/13, indicated the resident had potential for drug related complications associated with use of psychotropic medications, related to use of Haldol and sertraline.</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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	<p>Interventions included, but were not limited to, " Psychotropic medication risk/benefit and reduction plan as recommended by physician and pharmacist."</p> <p>On 11/5/13 at 12:00 p.m. a review of the resident's Medication Administration Records indicated the resident had received Haloperidol (Haldol) 1 Miligram by mouth on November 1, 2,3, and 4. The Medication Administration Record indicated the order date was 03/13/13 at 1310 (1:10 P.M.).</p> <p>On 11/7/13 a review of Clinical Pharmacist Letter to Physician Services, dated 10/29/13 and addressed to (physician's name) indicated a recommendation to reduce resident # 166 dose of Haldol to 0.5 milligram's daily</p> <p>On 11/6/13 at 10:30 a.m. review of clinical record lacked documentation to indicate the medication had been reduced or that the Physician had addressed the recommendation.</p> <p>On 11/6/13 between 11:00 a.m. and 12:30 p.m. interview with Unit Manager #17 indicated (physician's name) would be in on Friday, November 8th.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY AVE ELKHART, IN 46517
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	3.1-48(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interviews, the facility failed to ensure the medication error rate was less than 5 percent. This affected Resident #D and Resident #156. There were a total of 2 timing errors made out of 25 medications observed for a medication error rate of 8 percent.</p> <p>Findings include:</p> <p>1. During an observation of a blood glucose test for Resident #D, conducted on 11/06/13 at 11:34 A.M., LPN #23 assessed Resident D's blood glucose level to be 121 .</p> <p>During the observation of a medication administration pass, conducted on 11/06/13 at 11:47 A.M., LPN #22 gave Resident #D, 20 units of Humalog insulin in her room. The resident was not observed to receive any food until 12:26 P.M., 44 minutes after she was given her insulin.</p> <p>Review of the clinical record for Resident #D, on 11/07/13 at 2:30 P.M., indicated the resident had a</p>	F000332	<p>F-3321. Resident #81 suffered no adverse outcomes related to the alleged deficient practice. Resident #81 had their primary care physician notified of the medication error and new orders were received to discontinue the sliding scale insulin.2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. * Residents with insulin orders were reviewed for the past 30-days in an attempt to identify any other residents affected by the alleged deficient practice. 3. Licensed Nursing staff will be reeducated by the Director of Clinical Education by 12/8/13 on the Diabetes Management Guidelines including general principles of medication pass and administration of insulin. * Medication Administration Records will be reviewed daily by Nursing Administration to ensure residents with insulin orders received the insulin according to the manufactures recommendation and/or facility management guidelines. 4. Medication pass observations will be completed by Nursing Administration 3x per week to ensure medication error rates remain below 5%. Results of</p>	12/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013
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	<p>physician's order, dated 07/12/13, for Novolog Solution 100 units/ml. Inject 20 units subcutaneously one time a day related to diabetes. The order indicated the dose was scheduled to be given at 1200 (12:00 P.M.).</p> <p>A subsequent order, dated 10/29/13 at 1520 (3:20 P.M.) indicated all routine Novolog orders were to be reduced by 5 units. Although the electronic Medication Administration Record, observed on 11/06/13 at 11:47 A.M., indicated 20 units were to be given. However, a copy of the MAR for November 2013 indicated 15 units was indicated as having been administered on 11/06/13 at 11:47 A.M.</p> <p>2. On 11/06/13 at 10:56 A.M., LPN #24 assessed the blood glucose level of Resident #156. Resident #156's blood sugar was assessed to be 204.</p> <p>On 11/06/13 at 11:52 A.M., LPN #22 gave Resident #156 a total of 13 units of Novolog insulin.</p> <p>Review of the clinical record for Resident #156, on 11/07/13 at 2:00 P.M., indicated the resident was to receive 5 units of Novolog for blood glucose levels between 221 and 240. The resident was also to receive 8</p>		these audits will be reported monthly for 6 months to the QAA committee, and then the QAA committee will determine the need for additional auditing until a threshold of 100% is achieved. 5. Date of compliance 12/8/13		

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	<p>units of Novolog routinely before meals.</p> <p>Resident #156 did not receive her meal tray until 12:13 P.M.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F000364 SS=E	<p>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. Based on observation, interview, and record review, the facility failed to serve food at the proper temperature at point of service. This had the potential to affect 15 of 15 resident's that received hall trays on the Southwest hall.</p> <p>Findings include:</p> <p>On 10/31/13 at 1:28 P.M., an interview with Resident #143 indicated sometimes the food was too cold. The resident further indicated she normally eats in the dining room but this particular day the staff did not awaken her so she had to eat in her room.</p> <p>On 11/1/13 at 9:47 A.M., an interview with Resident #D indicated the food is always cold.</p> <p>On 11/1/13 at 1:56 P.M., an interview with Resident # 56 indicated the food was always cold, the resident further indicated she sometimes asks the staff to warm the food but it doesn't</p>	F000364	F-364 1 Resident #56 and 143 suffered no adverse outcomes related to the alleged deficient practice. Resident D was not identified in the survey sample. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. * A comprehensive review of current menus and receipts have been completed by the Executive Director and Registered Dietitian to ensure food is being prepared and served to meet the needs of the residents.3. Dietary staff have been in-serviced by the Director of Dining services on food preparation that conserves appearance, palatability and temperature control by 12/8/13.* The Executive Director and/or designee will complete a resident tray assessment to ensure food is attractive and palatable. * A food committee will be held weekly for a period of four weeks to identify areas of food temperature and palatability. Food committee will be held monthly thereafter. 4. Meal tray audits will be performed by the Director of Dining Services that will include documentation of food tray temperatures. The results of those audits will be	12/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
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	<p>always happen.</p> <p>On 11/5/13 at 12:09 P.M., an observation indicated the lunch trays were to be delivered at 12:00 P.M. on the Southwest hall, the trays arrived at 12:09 P.M. The last tray on the cart was passed at 12:27 P.M. The Dietary Manager checked the temperature of the last tray on the cart. The temperature of the milk was 60 degrees Fahrenheit (F), the mashed potatoes and gravy were 120 degrees (F), the egg quiche was 112 degrees (F), and the brussel sprouts were 92 degrees (F).</p> <p>On 11/5/13 at 12:40 P.M., an interview with the Dietary Manager indicated the hot food at the point of delivery should be at least 140 degrees (F), and the cold food should be 40 degrees (F) or below.</p> <p>On 11/5/13 at 2:00 P.M., record review of the resident council minutes, dated 8/20/13, indicated "...New Business: A. all meals not served hot. Number of residents who share the concern 9 out of 9...Department Response: ED (Executive Director) samples meal trays each day to ensure proper temp...If the issue has not been resolved to the resident's satisfaction,</p>		<p>forwarded to the QA&A committee on a monthly basis until a threshold of 100% is achieved. 5. Date of Compliance 12/8/13</p>	

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	<p>resubmit the concern with a request for an explanation of the reasons or barriers to resolution...not resolved given back to dietary...."</p> <p>On 11/6/13 at 9:40 A.M., an interview with the DON (Director of Nursing) indicated we have had complaints about the food temperatures for a while. We did have a hall cart that would plug in to keep the food warm, but it is beyond repair. The Administrator has been checking the food temperatures daily before the food leaves the kitchen. The DON further indicated that they do not currently have a policy of food temperatures at the point of service.</p> <p>On 11/6/13 at 10:00 A.M., record review of the test tray evaluation form, dated 10/28/13, indicated "...actual temp (temperature) for hot entree and cold fruit adequate...."</p> <p>On 11/6/13 at 11:05 A.M., record review of the current policy titled "Food Temperatures" received from the Director of Nursing indicated "...the director of dining or designee is responsible for ensuring that all food is at the proper serving temperature(s) before meal service starts...."</p>			

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	<p>This federal tag relates to Complaint IN00138396.</p> <p>3.1-21(a)(2)</p> <p>2. During an interview with alert and oriented Resident #143, conducted on 10/31/13 at 1:28 P.M., she indicated her food was sometimes served too cold, especially when she ate in her room.</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>1. Based on observation, interview, and record review, the facility failed to ensure the kitchen equipment was clean and sanitary, related to a dirty ice machine, rust on the surface of metal drawers and shelving and a concrete floor in the food prep area that had peeling paint and broken concrete. This had the potential to affect 151 of 151 residents who receive meals and ice from 1 of 1 kitchen.</p> <p>2. Based on observation, interview, and record review, the facility failed to distribute and serve food under sanitary conditions in regard to hand washing during delivery of meal trays for 22 of 22 residents who ate in the Garden Lounge dining room. (CNA #15 and CNA #16)</p> <p>Findings include:</p> <p>1. On 10/30/13 at 10:15 A.M., during the initial kitchen tour with the Dietary Manager, the following was observed:</p>	F000371	F-3711. There were no adverse outcomes related to the alleged deficient practice. The ice machine was cleaned during the time of the survey and has been cleaned on a weekly basis since that time. The Concrete floor is slated for repair by 12/8/13. The stainless Steele shelves have been replaced to ensure no rusting remains. *CNA 15 & 16 were not identified during the survey exit. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Dietary staff have been in-serviced on proper sanitation as it relates to cleaning the ice machine by 12/8/13* Nursing staff will be in-serviced by the Director of clinical education on proper hand washing time frames during meal service by 12/8/13.4. Director of Dining Services will complete dining room observations to ensure proper hand washing occurs during meal service. Ice machine logs will be reviewed and cleaning logs data will be forwarded to the QA&A on a monthly basis.. Results of hand washing during meals will be	12/08/2013	

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	<p>the kitchen floor is painted concrete, in front of the walk in cooler and freezer the paint is peeling and worn down to the bare concrete revealing three different colors of paint on the floor. An area under the stand mixer was observed to have broken concrete with no paint covering the area. Three metal pull out drawers that had measuring utensils inside had rust around the top edges. Two metal cabinets were observed to have rust on the surface of the shelves, there was a shelf protector observed to be pushed over in the corner of the shelf leaving the pots and pans sitting directly on top of the rust.</p> <p>Two ice machines were observed in a hallway outside of the kitchen area. One ice machine was not functioning and the second ice machine had a black substance across the inside of the lid area. The lid on the second ice machine also had cracks around the hinges.</p> <p>On 10/30/13 at 10:30 A.M., an interview with the Dietary Manager indicated she would have the Maintenance person clean the second ice machine immediately, and further indicated the cleaning of the ice machine is the responsibility of the Maintenance Department. The Dietary Manager also indicated the</p>		tallied with results being reported to the QA&A by the Director of Dining Services monthly for 6 months and the Quarterly thereafter until a threshold of 100% is achieved. Date of Compliance: 12/8/13				

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	<p>kitchen floor is suppose to be replaced but is unsure when that will happen.</p> <p>On 10/30/13 at 11:30 A.M., an interview with the Maintenance Supervisor indicated that the ice machines were to be cleaned by the housekeeping department. At 11:40 A.M., the Maintenance Director indicated that he was incorrecr when speaking earlier it is actually the Dietary Department's responsibility to clean the ice machines. At 12:00 P.M., the Maintenance Supervisor indicated it is now his responsibility to clean the ice machines.</p> <p>On 10/31/13 at 11:00 A.M., record review of the current policy titled "Cleaning Ice Machines" received from the Dietary Manager indicated "...Follow the steps below daily to clean the ice machine...2. Sanitize dispensing area or door to chest...Follow the steps below monthly to clean chest ice machines:...2. Place all ice into large containers stored in freezers for use while ice machine is being cleaned. Important: Do not return this ice to the ice machine...4. Scrub all surfaces using a clean cloth and detergent solution. 5. After cleaning, rinse chest with water. 6. Rinse again using a</p>			

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	<p>sanitizing solution at the appropriate strength. 7. Allow chest to air-dry...."</p> <p>On 11/8/13 at 9:15 A.M., an interview with the Administrator indicated the kitchen floor has been in this condition for at least 3 years. The Administrator along with the Maintenance Supervisor toured the building quarterly and wrote down what we felt was the most urgent need for repair. We then turn into our corporate a quarterly deferred maintenance plan. The corporation decided what monies will be allocated for building maintenance. The Administrator further indicated she has had a few urgent things that needed replaced and that depleted the money for this quarter, and she was unsure when exactly the kitchen floor would be replaced.</p> <p>2. On 10/30/13 at 11:42 A.M., during dining service in the Garden Lounge dining room CNA #15 and CNA #16 was observed to wash their hands for 7 seconds. Then CNA #16 was observed washing hands for 9 seconds while serving resident food trays.</p> <p>On 10/30/13 at 12:15 P.M., an interview with CNA #16 regarding proper hand washing technique</p>			

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	<p>indicated she was to sing 'Happy Birthday' twice, she was unable to indicate second duration.</p> <p>On 10/31/13 at 2:00 P.M., record review of the current policy titled "Hand Washing" received from the Director of Nursing indicated "...Wash hands before and after resident contact...Wash hands when soiled...7. Rub hands briskly using sufficient lather and friction for ten to fifteen seconds...."</p> <p>3.1-21(i)(3)</p>			

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to administer insulin according to the manufacturers recommendations for 1 of 5 residents reviewed for insulin administration. (Resident D)</p> <p>Findings include:</p> <p>On 11/4/13 at 3:15 P.M., record review indicated Resident D's diagnoses included but were not limited to "...diabetes type II, glaucoma, edema, chronic kidney disease, diabetic retinopathy, osteoporosis and hypertension...."</p>	F000425	F-4251. Resident D was not identified during the duration of the survey. Residents who have a diagnosis of diabetes were reviewed for their current individual Diabetes Management Plan.2. Residents with diabetes have the potential to be affected by the alleged deficient practice. Residents who have active physician orders for insulin were reviewed. Residents primary care physician have reviewed the diabetes management plan and residents who were able to be switched to a longer acting analog insulin. 3. 3. Licensed Nursing staff will be reeducated by the Director of Clinical	12/08/2013	

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	<p>The quarterly MDS (Minimum Data Set) assessment, completed on 8/12/13, indicated that Resident D had no cognitive impairment and required supervision for toilet use, locomotion on the unit and transfers.</p> <p>The Fall Risk Assessment, dated 10/12-10/18/13, indicated that Resident D's score was 10. A total score of 10 or above deems resident at risk.</p> <p>The Post Fall Investigation, dated 10/16/13, indicated "...fall details: fell from shower/toilet/commode. Physical assessment after fall: blood glucose 29, lethargic. Swollen area above left eye purple in color...Reenactment of fall: BS (blood sugar) was checked at 1755 [5:55 P.M.] BS 130. Resident told the nurse she would be down to supper shortly she had a few things she wanted to do...CNA was in the room approx [approximately] 1815 [6:15 P.M.] checking to see if she needed anything nothing unusual was noted...At 1830 [6:30 P.M.] the Unit Manager went to assist residents to the dining room. Resident D was in the bathroom and said she would be out when she was done washing up in the bathroom...At 1900 [7:00 P.M.] I was notified that the resident was on</p>		<p>Education by 12/8/13 on the Diabetes Management Guidelines including general principles of medication pass and administration of insulin. * Medication Administration Records will be reviewed daily by Nursing Administration to ensure residents with insulin orders received the insulin according to the manufactures recommendation and/or facility management guidelines. 4. Medication pass observations will be completed by Nursing Administration 3x per week to ensure medication error rates remain below 5%. Results of these audits will be reported monthly for 6 months to the QAA committee, and then the QAA committee will determine the need until a threshold of 100% is achieved. 5. Date of compliance 12/8/13</p>	

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	<p>the floor. First reported by: visitor at 1900 [7:00 P.M.]...."</p> <p>On 11/4/13 at 3:30 P.M., review of care plan indicated the problem: At risk for falls related to: History of falls, occasional incontinence and visual impairment related to glaucoma and diabetic retinopathy. Interventions included but were not limited to "...resident to notify staff when feeling symptomatic of low blood sugar (dizzy, weak, cold sweat, blurred vision)...."</p> <p>A MAR (Medication Administration Record), dated October 2013, indicated "...Novolog insulin inject 34 units subcutaneous one time a day at 5:00 P.M...Novolog Insulin per sliding scale before meals...Accuchecks before meals and at bedtime...." A review of the MAR indicated on 10/16/13 the resident's blood sugar was 130 at 4:00 P.M., no sliding scale insulin was given. At 4:51 P.M., the resident received 34 units of Novolog insulin. At 6:00 P.M. an accucheck was done and the resident's blood sugar was 130.</p> <p>On 11/7/13 at 10:30 A.M., review of current "Novolog Package Insert and Label Information" received from the DON (Director of Nursing) indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517		
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	<p>"...Because Novolog has a more rapid onset and a shorter duration of activity than human regular insulin, it should be injected immediately (within 5-10 minutes) before a meal...."</p> <p>On 11/7/13 at 10:45 A.M., review of current "Diabetes Management Guideline" received from the DON indicated "...Medication Management: Rapid Acting (bolus or mealtime) The rapid acting insulin's (Humalog, Novolog and Apidra) are a better physiological fit for managing mealtime glucose elevation. Rapid Acting Insulin's are sometimes safest given after the meal...."</p> <p>On 11/7/13 at 2:30 P.M., an interview with LPN #17 indicated, Resident D is scheduled to receive an injection of 34 units of Novolog Insulin every evening around 5:00 P.M. The resident eats her meals in the Rosewood dining room and the first service does not start until 6:10 P.M., that is a problem since her insulin is rapid acting.</p> <p>This federal tag relates to Complaint IN00138396 and IN00138613.</p> <p>3.1-25(a)</p>				

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure pharmacy recommendations were acted upon timely for 2 of 5 residents reviewed for medications. (Resident #C and Resident #166)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record for Resident #C was reviewed on 11/04/13 at 3:08 P.M. Resident C was admitted to the facility on 10/12/11 with diagnosis, including but not limited to: psychosis, alzheimer's disease, hypertension, epilepsy, esophageal reflux, hyperlipidemia, and depressive disorder. <p>The resident had received the antipsychotic medication, Risperdal 0.125 mg at noon and at bedtime since 07/18/12 for "unspecified psychosis." The resident's medical symptom tracked in respect to the medication was agitation and</p>	F000428	F-4281. Resident #166 has had her anti-psychotic medication clarified with the physician and the gradual dose reduction was accepted at the time of the clarification. Resident's plan of care has been updated to reflect the use of this medication. Resident 166 did not suffer any adverse outcomes related to the alleged deficient practice. Resident C was not identified in the survey sample. 2. Residents with anti-psychotic medications have the potential to be affected by the alleged deficient practice. * Residents who receive Anti-psychotic medications have been reviewed and care plans modified if appropriate. Residents who are in need of a gradual dose will be forwarded to the attending physician for review and follow up. The Pharmacy Consultant will continue monthly visits to the facility and will inform Facility Management of non completed recommendations. 3. Licensed Nursing Staff and the Interdisciplinary team will be re-educated by the Director of	12/08/2013	

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	<p>uncooperative/refusing care.</p> <p>The resident also had received the antidepressants, Wellbutrin 150 mg once a day since 09/13/13 for "unspecified psychosis" and Citalopram Hydrobromide 20 mg at bedtime since 10/26/11 for depressive disorder. On 11/04/13, the resident was placed on Cymbalta 60 mg at bedtime for depressive disorder. However, interview with the Director of Nursing, on 11/08/13 at 9:10 A.M. indicated the Cymbalta was actually ordered to address pain issues, not depression.</p> <p>Review of the pharmacy reports for Resident #C from October 2012 - October 2013 indicated he recommended a Gradual dose reduction on 8 occasions for either the Celexa medication or the Risperdal. The dates of the requests for gradual dose reductions were: 12/27/12, 02/25/13, 03/27/13, 04/29/13, 06/29/13, 07/30/13, 08/29/13, and 10/29/13.</p> <p>On 02/13/13 Resident #C was seen by the facility's psychiatrist at the time. Although the note indicated "No behaviors," and indicated a reduction in attention seeking and agitation, the psychiatrist indicated he would</p>		<p>Clinical Education by 12/8/13 on Anti-psychotic medications and the gradual dose reduction process. 4. Social Service Director's will complete Anti-Psychotic medication audits as well as the Pharmacy Consultant. The results of those audits will be reported by the Social Services staff monthly for 6 months and then the QAA committee will determine the need for additional auditing until a threshold of 100% is achieved. 5. Date of Compliance 12/8/13</p>		

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	<p>evaluate a reduction in the Risperdal in 3 - 6 months and marked a typed comment which read: "I have reviewed the patient's history, medications, response, and possible side effects. Medications are well tolerated and the patient is likely to be negatively impacted should the current medications be changed. There are no clinical indications to reduce psychiatric medications at this time here was no specific documentation on the Celexa reduction which had been requested previously by the pharmacist.</p> <p>Interview on 11/06/13 at 2:05 P.M. with the Administrator and a SSD, #28, indicated in June of 2013, (physician's name) who was our psychiatric provider, was abruptly terminated at (hospital name). He had called the facility and told them he was trying to establish his own private practice so he could continue treating residents here. We waited 30 - 60 days and he never came forth with provider number, etc. In September of 2013, Administrator met with IDT and signed contract with (name of a psychiatric provider group). The group then had to hire additional staff to service our type of building. They began providing psychiatric services the middle part of</p>			

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	<p>October 2013. The facility was aware there were residents due for GDR (gradual dose reductions) but the resident's primary care physician's would not address psychiatric medications. The Administrator indicated she was also going to ask the medical director to address some of the reduction but she was not confident he would comply.</p> <p>2. Resident # 166's record was reviewed on 11/4/13 at 2:50 p.m. The resident's diagnoses included, but were not limited to, alzheimer's disease, dementia with behavioral disturbances and depressive disorder not elsewhere classified.</p> <p>The Quarterly Minimum Data Set Assessment, dated 10/10/13, indicated the resident had a Brief Interview for Mental Status score of 03 which indicated severe cognitive impairment. She had a mood severity score of 00. She was coded for feeling tired or having little energy with the frequency of never or 1 day of the assessment period.</p> <p>A Careplan, date initiated 3/25/13 and updated 10/15/13, indicated the resident had potential for drug related complications associated with use of psychotropic medications, related to use of Haldol and sertraline.</p>				

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	<p>Interventions included, but were not limited to, ' Psychotropic medication risk/benefit and reduction plan as recommended by physician and pharmacist."</p> <p>On 11/5/13 at 12:00 p.m. a review of the resident's Medication Administration Records indicated the resident had received Haloperidol (Haldol) 1 Milogram by mouth on November 1, 2,3, and 4. The Medication Administration Record indicated the order date was 03/13/13 at 1310.</p> <p>On 11/7/13 a review of Clinical Pharmacist Letter to Physician Services, dated 10/29/13 and addressed to (physician's name) indicated a recommendation to reduce resident # 166 dose of Haldol to 0.5 milligram's daily</p> <p>On 11/6/13 at 10:30a..m. review of clinical record lacked documentation to indicate the medication had been reduced or that the Physician had addressed the recommendation.</p> <p>On 11/6/13 between 11:00 a.m. and 12:30 p.m. interview with Unit Manager #17 indicated (physician's name) would be in on Friday, November 8th.</p>				

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY AVE ELKHART, IN 46517
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	3.1-25(j)			

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F000441 SS=E	<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, record review,</p>	F000441	F-4411. Licensed Nurses #10 & 11 were not identified during	12/08/2013			

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	<p>and interview, the facility failed to wash or sanitize hands prior to administration of medications for 6 of 6 residents observed during a medication pass on the Southwest Unit. (Resident #10, Resident #15, Resident #7, Resident #122, Resident #121 and Resident #72)</p> <p>Findings included:</p> <p>On 11-5-13 at 11:45 A.M., LPN #11 on the Southwest Unit was observed preparing and administering an oral medication to Resident #10. LPN #11 returned to the medication cart and documented the administration of the medication. She then proceeded to prepare to do a blood sugar test on Resident #72. The LPN returned to her cart and cleansed the glucometer with gloves on. She removed the gloves and documented the administration of the drug and blood sugar reading. She then prepared and administered an oral medication to resident #15. LPN #11 indicated she had hand sanitizer on her cart but gave no explanation as to why she wasn't using the product or washing her hands with soap and water with each medication pass.</p> <p>On 11-5-13 at 12:13 P.M., LPN #10 on the Southwest Unit was observed</p>		<p>the survey. Licensed nurses have been re-educated on proper hand washing during medication administration. 2. Residents' residing at the facility have the potential to be affected by the alleged deficient practice.3. Licensed Nursing staff has been in-serviced by the Director of Clinical Education by 12/8/13 on the procedure for proper hand washing as it relates to medication administration. The Director of Clinical Education will complete random Licensed Nurses competencies' on the Hand washing process. 4. Nursing Administration and/or the Director of Clinical Education will complete Hand washing observation audits monthly for 6 months to the QAA committee, and then the QAA committee will determine the need for additional auditing until a threshold of 100% is achieved.5. Date of Compliance 12/8/13</p>		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY AVE ELKHART, IN 46517
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	<p>preparing and administering an oral medication for Resident #122. LPN #10 returned to her medication cart and retrieved a glucometer (device to check a resident's blood sugar). She went into Resident #121's room with gloves on and checked the resident's blood sugar. The LPN returned to her medication cart, removed gloves and put the blood sugar results in the computer. She then prepared to draw up insulin for the resident. LPN #10 then donned gloves and went into the resident's room and gave the insulin injection. She returned to her medication cart cleansed the glucometer, removed the gloves and documented the injection. The LPN went to the dining room and assisted Resident #7 back to her room so an accucheck could be completed. LPN #10 administered the blood sugar test and insulin with gloves on. She returned to the medication cart cleansed the glucometer, removed her gloves and completed her documentation. LPN #10 was not sure about the hand washing policy but indicated she thought she only had to wash her hands after every other resident. She had no explanation as to why her hands weren't cleansed before and after each medication administration.</p>			

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	<p>During an interview on 11-5-13 at 2:25 P.M., the Southwest Unit Manager indicated nurses should be washing their hands with soap and water or using hand alcohol gel before and after each administration of medication. The census for area was 60 residents.</p> <p>On 11-6-13 at 11:20 A.M., a review of the policy titled "Medications Administration-General Guidelines" indicated "...Hand washing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass and when hands are visibly soiled or contaminated...." An approved sanitizer between hand washings was acceptable assuming hands are not visibly soiled.</p> <p>3.1-18(l)</p>				

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F000465 SS=E	<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 observations, record reviews, and interviews, the facility failed to maintain resident restrooms and/or rooms in a sanitary and comfortable manner for 6 of 40 residents reviewed and 5 additional residents. (Resident #33, 143, 193, 97, 126, and 94)</p> <p>Findings Include;</p> <p>1. On 11/7/13 between 2:00 p.m. and 3:15 p.m. an environmental tour was conducted with the Maintenance Director and the Executive Director. On the Southwest unit , in the bathroom for room #414, a brown substance about the size of a silver dollar with the appearance of fecal matter, was observed on the wall located just below the toilet paper holder.</p> <p>Interview with Maintenance director on 11/7/13 between 2:00 p.m. and 3:15 p.m. indicated it was a suspicious substance but that he did not know what it was.</p> <p>On 11/01/13 at 11:15 A.M., the walls</p>	F000465	F-465 1. Resident room 3 414,426,435,307,308,313,321,322,&323 have been deep cleaned as well as repairs completed to the scuffed walls with chipped paint2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Licensed Nurses, Certified Nursing Assistants, non Nursing staff as well as the Department Managers has been in-serviced by the Executive Director by 12/8/13 on reporting soiled walls and bath rooms, placing information into the building engines maintenance program for appropriate follow up and/or replacement. Guardian Angels will report any housekeeping/environmental issues during random round times. 4. The Maintenance Director and/or the Executive director will perform Environmental facility rounds monthly for 12 months. The results from those rounds will be reported to the QAA committee monthly for 12 months. The QAA committee will examine those results and determine the need for further auditing. 5. Date of compliance 12/8/13	12/08/2013			

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	<p>in bathroom and room of Room #426, by the trash can, entry way, and on east side of room were marred., missing paint and in some cases dry wall exposed. There were also several small holes in the east wall of the room.</p> <p>On 10/31/13 at 2:02 P.M., plastic loosely taped with blue painter's tape was noted on the large picture window for Room 435 on the southwest unit. Resident #143 indicated the plastic was on the window because cold air was coming in around the window.</p> <p>On 11/7/13 between 2:00p.m and 3:15 p.m. an environmental tour was conducted on the South unit with the Maintenance Director and Executive Director. On the South Unit, the bathrooms that were utilized for the residents in rooms 307,308, 312, 313, 321, 322, and 333 were observed to be marred along the right side of the wall of the bathroom.</p> <p>On 11/7/13 between 2:00 p.m. and 3:15 p.m. the Maintenance Director indicated, the facility was renovating 4 rooms per month. He indicated the process of the renovation was to gut the room to be renovated and the adjoining restroom and replace and</p>				

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	<p>fix everything. When asked if he had a schedule of rooms that will be renovated he indicated he did not have a schedule of the rooms to be renovated and the projected dates of renovation, he indicated the process of determining what rooms were renovated that month were based on severity of need for the room renovation.</p> <p>On 11/8/13 a action plan titled," Golden Living Center Originated Date: 6/1/13 updated 7/30/13 and 9/30/13 was reviewed. Goal/Objective F 252 Environment, Specific Action Steps: painter to paint 4 rooms per month and repair any areas of displaced dry wall or cove base. Person Responsible: Maintenance Director, Target Dae of Completion: 6/1/13, and Weekly Status/Progress: On going progress."</p> <p>Interview with the Executive Director, on 11/8/13 between 10:30 a.m. and 11:00 a.m., indicated that (name of a janitorial service) was contracted to clean the facility. When asked how often the rooms and restrooms were scheduled to be cleaned, she indicated (name of janitorial service) had a schedule that they used to determine what was to be cleaned and the frequency in which it was to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
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	<p>be cleaned.</p> <p>On 11/8/13 at 10:40 a.m., a Scope of Services Exhibit C was provided by the Executive Director. She indicated she had requested a policy from (janitorial service) and they provided her with the Scope of Services document.</p> <p>On 11/8/13 at 10:45 a.m. the Scope of Services Exhibit C was reviewed." 1. Areas to be Serviced 1.1.1 Resident Rooms and Restrooms. 2. Description of Services 2.2.1. Spot Clean walls, doors, door frames, and adjacent glass. 3. Scheduling of Services 3.1 Table. Vendor will clean the areas specified in the table below. The numbers shown below represent the number of times per week that a service will be performed., unless otherwise noted. (AN= As Needed, Q=Quarterly, B=Biannually, S= Scheduled Basis, M=Monthly, N/A=Non Applicable, Y= Yearly; 7=daily, 7days a week, 5=daily, Monday through Friday)." Review of Table area to be cleaned, indicated Resident Rooms and Restrooms Spot Clean the number 7 was indicated in the table box.</p> <p>On 10/31/13 a action plan titled, Golden Living Center with an</p>			

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	<p>originated date of 6/1/13 updated 7/30/13 and 9/30/13 was provided by the Executive Director."</p> <p>Goal/Objective F252 Environment</p> <p>Specific Action Steps: ABM staff re-inserviced on cleaning resident rooms, Person Responsible: ABM manager, Target Date of Completion: 7/30/13, Weekly Status/Progress Complete.</p> <p>3.1-19(f)</p>			