

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 3, 4, 5, 6, 7, 2015</p> <p>Facility number: 000033 Provider number: 155375 AIM number: 100266280</p> <p>Census bed type: SNF/NF: 51 Total: 51</p> <p>Census payor type: Medicare: 3 Medicaid: 42 Other : 6 Total: 51</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1</p>	F 0000		
F 0159 SS=B Bldg. 00	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the</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.

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	<p>resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other</p>			

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	<p>nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review the facility failed to provide residents access to their money in the Resident Trust Funds accounts during the evening hours for 4 of 32 residents reviewed for personal funds. (Resident #38, Resident #62, Resident #41, Resident #17)</p> <p>Findings include:</p> <p>During an interview on 8/4/15 at 11:54 A.M., Resident #38 indicated money from his/her resident fund account was not available on weekends and evenings.</p> <p>During an interview on 8/4/15 at 1:41 P.M., Resident #62 indicated that, if he/she wanted to withdraw cash from his/her resident fund account, the cash was available on weekends, but not during evening hours.</p> <p>During an interview on 8/5/15 at 10:37 A.M., Resident #17 indicated money was available during office hours Monday through Friday, but not on weekends or evenings.</p> <p>During an interview on 8/5/15 at 10:45 A.M., Resident #11 indicated money was</p>	F 0159	<p>F159B</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>All residents who have a Resident Trust account have the potential to be affected by this deficient practice. Resident #41 does not manage his resident trust account, his Guardian furnishes his needs and manages his account or facility will contact Guardian if resident request any items. Facility was not provided the names of resident #62, #38, and #17.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents who have a Resident Trust account have the potential to be affected by this deficient practice. Facility will send letter to resident and/or family representative informing them that a minimal amount of resident funds will be available to residents 24 hours per day, 7 days a week. This</p>	08/25/2015

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	<p>available during office hours Monday through Friday. Resident #11 further indicated residents were unable to get money during the evenings.</p> <p>The policy and procedure "Resident Trust Fund/Valuables" was provided by the Health Care Facility Administrator on 8/6/15 at 3:04 P.M. The policy did not identify the times during which a resident had access to his/her money from the Resident Trust Funds accounts.</p> <p>During an interview on 8/6/15 at 11:45 A.M., the Business Office Manager (BOM) indicated that residents did have access to their money on weekends, but not in the evenings. The BOM further indicated that, if she was not in the facility in the evening, residents would have to wait until the following morning to access their money from their resident accounts.</p> <p>During an interview on 8/6/15 at 2:19 P.M., the Healthcare Facility Administrator (HFA) indicated the residents' funds were not available during the evening hours throughout the week, but the residents did have access to their money on the weekends. The HFA further indicated the residents' funds would now be available 24 hours a day 7 days a week.</p>		<p>will be achieved by placing resident fund monies in the East End Medication Cart for after business hours purchasing.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>A minimal amount of resident funds will be available to residents after business hours 7 days a week. These monies will be securely placed in the East End Medication Cart. Business Office Manager and Nurse with access to the Medication Cart will be in-service on disbursement process.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>Business Office Manager or designee will ensure that monies are available in the East End Medication Cart for after hours use by residents 7 days a week. Business Office to reconcile monies weekly. This will be monitored through facility resident council monthly meetings for 6 months then quarterly times 2 then as needed. Resident Council</p>	

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F 0242 SS=D Bldg. 00	<p>3.1-6(f)(1)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident bathing preference and dietary choices were honored, for 2 of 2 residents reviewed for choices. (Resident #36, Resident #27)</p> <p>Findings include:</p> <p>1. On 8/4/15 at 11:42 A. M., Resident #36 was observed sitting up on edge of bed feeding herself lunch, no distress noted.</p> <p>On 8/5/15 at 9:47 A.M., Resident #36's clinical record was reviewed. Resident</p>	F 0242	<p>Meetings will be reviewed thru facility QAPI monthly for 6 months, quarterly times 2, than as needed for tracking and trends. Action plans will be developed as appropriate.</p> <p>Date the systemic changes will be completed: 8/25/15</p> <p>F242D</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #36 will be given ice-cream per request on Monday, Wednesday and Friday. Resident #27 will be given showers 2Xwkly or as needed. Care Plan updated to reflect preferences.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified</p>	08/25/2015

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	<p>#36 had been admitted to the facility on 6/5/11. Her diagnoses included but were not limited to, constipation, diarrhea, dyspepsia and other disorders function of stomach, hypothyroidism and osteoporosis. Resident #36's Minimum Data Set (MDS) assessment dated 6/18/15, indicated a cognitive score of 15, which indicated her cognition was intact. The CNA (Certified Nursing Assistant) assignment sheet (updated on 5/28/15) was received and reviewed on 8/6/15 at 9:05 A.M. The meal section of the assignment sheet indicated Resident #36 dined in her room feeding herself. The assignment sheet indicated Resident #36 received a shake with dinner.</p> <p>A Weights and Vitals Summary sheet reviewed on 8/6/15 at 9:30 A.M., indicated the following weights: 1/6/15 weight of 107.2 lbs (pounds), 1/8/15 weight of 103.4 lbs, 2/7/15 weight of 101.6 lbs, 3/18/15 weight of 93.8 lbs, 3/24/15 weight of 95.8 lbs, 4/8/15 weight of 100 lbs, 5/4/15 weight of 98 lbs, 6/10/15 weight of 95 lbs, 7/9/15 weight of 96.4 lbs, and 8/3/15 weight of 94.6 lbs.</p> <p>A progress note (by Dietary Service Manager-DSM) dated 8/4/15 at 1:36 P.M., indicated, "Resident has been asking for ice cream several times daily was explained to her she gets ice cream</p>		<p>and what corrective action will be taken:</p> <p>All resident have the potential to be affected by this deficient practice. Facility will provide various snacks for resident choice between meals. Nursing staff will honor residents choice of bathing preferences. Nursing staff will document into computer system scheduled showers or refusal of showers daily. Care Plan updated to reflect preferences.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Facility will have an assortment of snacks to offer residents to choose from when requested. . CNA will enter resident preference to receive or refuse shower in facility Kiosk. Follow up by Charge Nurse or designee will then be reviewed to ensure documentation has been input into computer system. In-serviced staff on honoring resident preferences.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p>	

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	<p>when it is menued and also if its menued for snacks. explained [sic] to her we do not serve ice cream daily will cont. [continue] to offer her snacks which we keep in stock. she [sic] continuously asks her staff for this several staff has explained this to her. will [sic] continue to explain this to her."</p> <p>A progress note (by DSM) dated 8/4/15 at 1:41 P.M., indicated, "talked with resident about purchasing a freezer to put in her room to keep snacks and ice cream in for her enjoyment. but [sic]she flatly stated she would not spend the money for that. explained[sic] if she had her own refridgerater [sic] she could keep anything she wanted in it. but does not want to spend money on this. will [sic] cont [continue] to offer other snacks."</p> <p>A progress note (by Social Service Director-SSD) dated 8/5/15 at 8:34 A.M., indicated, "This writer spoke to resident this am about a refrigator [sic]. Resident was concerned didn't have enough room for one. Resident was explained that she had plenty of room for one and would be very convenient for her to have snacks at bedside that she preferred and updated her that other residents have there own frig [refrigerator] in rooms. Resident ask about how much they cost. Resident stated that she was not going to buy one</p>		<p>DSM/or designee will meet with residents about food preferences. Social Service Director or designee will monitor Resident Choices through the monthly Resident Council Meeting and monthly Food Committee meeting for 6 months then quarterly times 2, then as needed. Director of Nursing Services or designee will monitor 5 times weekly for residents receiving showers and documentation to support. This will be reviewed during the monthly QAPI meeting for 6 months then quarterly times 2, then as needed for any track or trending.</p> <p>Date the systemic changes will be completed: 8/25/15</p>	

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	<p>and thought facility would furnish them. Resident was explained that facility does not furnish individual frigrators [sic] that residents purchase their own. Resident was informed how much money she has in her account and updated that staff could assist her with getting items out of the refrigrator [sic]. Resident is offered snacks that facility purchases. Resident voiced no concerns."</p> <p>On 8/6/15 at 10:55 A.M., the Registered Dietician (RD) was interviewed regarding weight loss and supplements. The RD indicated Resident #36 had been ill with an upper respiratory infection in March 2015 and weight loss had been noted. She indicated that currently Resident #36 chooses her own menu with the assistance of staff daily.</p> <p>A RD progress note dated 8/6/15 at 11:56 A.M., indicated, "... Slight weight loss trend noted: 1.8# (pounds)/1.9% loss x 30 days, 3.4#/3.5% loss x 90 days, 7#/6.9% loss x 180 days; while not considered significant, is concerning; res [resident] had been on weekly weights through April 2015--see previous RD/weight note (4/14/15)-- and had actually re-gained weight at a significant weight; spoke with res this afternoon regarding her current diet and snack preferences; DSM [Dietary Service</p>			

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	<p>Manager] reports res [resident] has been requesting ice-cream fairly routinely (multiple times daily)--facility had made suggestion for res to purchase a personal fridge so that she may keep snacks at bedside; res declined suggestion.</p> <p>Preferences updated; she continues on a regular diet and is asked what she prefers to receive at meals from the main-meals or Bristo Menu; review of her daily selections suggested fairly well-balanced choices...did taste-test a Frozen Nutritional Treat with res this afternoon--however res reported distaste; discussed snacks which are available daily, including various crackers, sandwiches, pudding etc. however res declined all offers, but states she would like ice-cream 3 x/week at lunch--recommend send ice-cream on Mon [Monday], Wed [Wednesday], Fri [Friday] at lunch; add to weekly weights d/t weight trend."</p> <p>On 8/7/15 at 1:58 P.M., during interview with the Administrator, the Administrator was made aware of Resident #36's weight loss and resident's request for an ice cream supplement. The Administrator indicated Resident #36 has enough money to buy a refrigerator and her snacks. The Administrator indicated the facility has a food budget that does not provide ice cream daily, but does provide</p>			

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	<p>other snacks.</p> <p>2. On 8/4/15 9:40 A.M., Resident #27 was observed to be propelling self in the hallway in his/her wheel chair.</p> <p>During a family interview on 8/4/15 at 1:34 P.M., the family of Resident #27 indicated they felt Resident #27's bathing choices were not being honored. The family member indicated Resident #27 was supposed to receive at least two showers weekly but was unsure if they were being completed. The family member indicated Resident #27 often had body odor when they would visit.</p> <p>During an interview on 8/6/15 at 2:56 P.M., with LPN #9, he/she indicated residents received at least two showers weekly and if they were not given a shower for any reason the Certified Nursing Assistants (CNA) were to notify the nurse so it could be documented and try to approach the resident later and offer the bath again.</p> <p>The clinical record for Resident #27 was reviewed on 8/6/15 at 9:30 A.M., diagnoses included, but were not limited to, dementia without behavioral disturbances and depression.</p>			

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	<p>The care plans included, but were not limited to, "I have a physical functioning deficit related to: Self care impairment. I require total dependence with bathing; extensive assistance with toileting, personal hygiene, dressing, bed mobility, transfers; limited assistance with locomotion and ambulation... ..I will be bathed, dressed and well groomed daily, assisted with showers two times weekly..." initiated on 7/23/2012. The interventions included, but were not limited to, "...Give am bath. Shower two times weekly..." initiated 7/23/15.</p> <p>The ACU (Alzheimer's Care Unit) CNA assignment sheet was reviewed on 8/6/15 at 10:00 A.M. It indicated Resident #27's showers were scheduled for day shift on Tuesday and Fridays, and that Resident #27 experienced incontinence episodes and required assistance of one to transfer.</p> <p>The ADL (activities of daily living) flow sheet from 6/1/15 through 8/6/15 for Resident #27 was reviewed on 8/7/15 at 10:00 A.M. The bathing record for Resident #27 was as follows:</p> <p>Week of June 1 through June 6th, 2015, Resident #27 received 1 of 2 scheduled showers.</p> <p>Week of June 6 through June 26th, 2015, Resident #27 received 1 of 2 scheduled</p>			

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F 0282 SS=D Bldg. 00	<p>showers. Week of June 27 through July 4th, 2015, Resident #27 received 1 of 2 scheduled showers. Week of July 26th through August 1st 2015, Resident #27 received no scheduled showers.</p> <p>The nursing notes for Resident #27 were reviewed from June 1st through August 6th 2015. No refusal of showers were documented.</p> <p>During an interview with CNA #15 on 8/7/15 at 2:45 P.M., she indicated if a resident refused a shower she/he would attempt to give it again later in the day. CNA #15 further indicated that if resident still refused he/she indicated she/he would notify the nurse.</p> <p>3.1-3(v)(1) 3.1-3(u)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	F 0282		08/25/2015

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	<p>Based on observation, interview, and record review, the facility failed to ensure an intervention ordered by the physician for a pressure area was not followed for 1 of 3 residents who met the criteria for review of pressure ulcers. (Resident #33)</p> <p>Findings include:</p> <p>Resident #33 was observed on 8/6/14 at 9:41 P.M., sitting in a Broda chair in his/her room with both feet floated on a pillow.</p> <p>The clinical record of Resident #33 was reviewed on 8/22/14 at 10:19 A.M. The record indicated resident #33 was admitted on 11/26/15. The diagnoses of Resident #33 included, but were not limited to, dementia with paranoid delusion and diabetes.</p> <p>A Braden Scale for predicting pressure sore risk was completed on 2/18/15 and indicated Resident #33 was at risk to develop a pressure sore.</p> <p>A Physician's order dated 5/18/15 (no time documented) read as follows: "...1 D/C [discontinue] heel protectors...(deep tissue injury to L [left heel])"</p> <p>A Progress note dated 6/2/15 at 9:57 A.M., read as follows, "upon getting</p>		<p>F282D</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Corrective action for this citation was corrected on 6/16/15.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents have the potential to be affected by this deficient practice. New or discontinued orders will be reviewed during facility start up meeting to ensure orders have been followed in a timely manner.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>DNS or Designee will review 5 times weekly during facility start up meeting any new or discontinued orders to ensure orders have been addressed. Nursing staff in-serviced on following new and discontinued physician orders.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>resident [sic] ready...This nurse noted upon removal of bil [bilateral] heel protectors dark area to inner aspect of left heel...total care...bil heel protectors on when in bed."</p> <p>A Progress note dated 6/3/15 at 14:25 A.M., read as follows, "Tx [treatment] cont [continues] to left heel area very red this day. Bil heel protectors on with feet floated on pillows when placed in bed resident [sic] ready...This nurse noted upon removal of bil [bilateral] heel protectors dark area to inner aspect of left heel...total care."</p> <p>A "WOUND EVALUATION FLOW SHEET" dated 6/2/15, indicated Resident #33 had developed a dark area (unstaggable pressure area) on the inner aspect of the left heel and measured 3 cm by 3 cm (centimeters). The additional comments section documented, "Bi [bilateral] heel protectors intact."</p> <p>A "WOUND EVALUATION FLOW SHEET" dated 6/9/15, indicated Resident #33's unstaggable pressure area measured 4 cm by 4.1 cm. The additional comments section documented, "Bi [bilateral] heel protectors when in bed - float feet on pillow"</p> <p>A "WOUND EVALUATION FLOW</p>		<p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>Director of Nursing or Designee will review 5 times weekly during facility start up meeting any new or discontinued orders to ensure orders have been addressed. This will be monitor by our QAPI committee monthly meetings for 6 months then quarterly times 2, then as needed for any track or trending.</p> <p>Date the systemic changes will be completed: 8/25/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2015
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	<p>SHEET" dated 6/16/15, indicated Resident #33's unstagable pressure area measured 3.5 cm by 2.8 cm. The additional comments section documented, "Bi [bilateral] heel protectors when in bed - float feet on pillow"</p> <p>The Treatment Administration Record (TAR) dated May 2015 for Resident #33 lacked documentation of the Physician's order dated 5/18/15, "D/C the use of heel protectors"</p> <p>The Treatment Administration Record (TAR) dated June 2015, for Resident #33, lacked documentation of the Physician's order dated 5/18/15, "D/C the use of heel protectors"</p> <p>The policy and procedure for Physician Telephone Orders was provided by the Health Care Facility's Administrator on 8/7/15 at 4:02 P.M., and it read as follows: "1. Licensed Nurse will document all physician's verbal and telephone orders into Point Click Care"</p> <p>During an interview on 8/7/15 at 1:59 P.M., the Director of Nursing indicated the new Physician's order should have been documented on the treatment record and use of the heel protectors should have been discontinued.</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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F 0314 SS=D Bldg. 00	<p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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, interview, and record review, the facility failed to ensure a resident who had been admitted without a pressure sore did not develop a pressure sore and an intervention to relieve pressure had not been implemented for 1 of 3 residents who met the criteria for pressure sore review. (Resident #40)</p> <p>Findings include:</p> <p>On 8/4/15 at 9:50 A.M., during interview with the Director of Nursing (DON), the DON indicated Resident #40 had a pressure sore on her chin. The DON</p>	F 0314	<p>F314D</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>A soft neck cushion placed on resident #40 to prevent infection and new sores from developing. Care Plan updated to reflect intervention.</p> <p>How other residents having the potential to be affected by the same</p>	08/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>indicated the resident's neck was contracted and held in a flexed position. The DON indicated the facility keeps padding between the neck and the chest area. The DON indicated the pressure sore was a stage 3.</p> <p>On 8/4/15 at 11:30 A.M., Resident #40 was observed sleeping on a specialty bed in a supine position. Resident #40 was wearing heel protectors on both feet and her feet were elevated on a pillow. Resident #40 's neck was in a flexed position resting on her chest. No positioning device was observed in place between her chin and chest. At that time, CNA #3 indicated Resident #40 had her neck in a flexed position since admission to the facility.</p> <p>On 8/4/15 at 1:25 P.M., Resident #40 was observed in bed (specialty bed) positioned on her back, and her neck was in a forward flexed position with her left chin area laying on her chest. No padding was in place between her neck and chest to prevent skin to skin contact.</p> <p>On 8/4/15 at 4:10 P.M., Resident #40's clinical record was reviewed. Her current admission to the facility was on 3/19/15. Her admission Minimum Data Set(MDS) assessment dated 3/27/15 indicated extensive assistance of 2 or more staff</p>		<p>deficient practice will be identified and what corrective action will be taken:</p> <p>All residents have the potential to be affected by this deficient practice. Evaluate and use positioning devices as indicated to prevent skin to skin contact on any resident who is admitted with the potential to develop pressures areas.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Evaluate and use positioning devices as indicated to prevent skin to skin contact on any resident who is admitted with the potential to develop pressures areas. DNS or designee will audited during weekly skin review, quarterly interdisciplinary resident review and admission/yearly clinical health assessment or change of condition. In-serviced nursing staff on residents with the potential to develop pressure areas and use of positioning devices.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be</p>	

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	<p>needed for bed mobility and transfer and walk in room had not occurred in the 7 day assessment period. Her Quarterly MDS assessment dated 6/24/15 indicated a cognition score of 8 (moderate cognitive impairment) and extensive assistance of 2 staff for bed mobility. Transfer and walk in room had not occurred in the 7 day assessment period. The 7/10/15 Significant Change MDS indicated a cognitive score of 7 (severe cognitive impairment) and extensive assistance of 2 staff for bed mobility. Transfer and walk in room had not occurred in the 7 day assessment period.</p> <p>A care plan problem of pressure ulcer actual or at risk was initiated on 3/30/15. The goal was "Skin will remain intact." Interventions included, but were not limited to, "...Float heels...Provide pressure reduction/relieving mattress, Provide thorough skin care after incontinent episodes...Turn and reposition..." The 3/30/15 care plan did not address the resident's neck contracture and intervention to prevent skin contact or pressure.</p> <p>A care plan problem of "Has Stage 111[3] pressure ulcer under chin left side of jaw line. Has neck contracture, hold neck in lateral flexion. Date initiated : "7/14/15...interventions included, but</p>		<p>put into place:</p> <p>DNS or designee will audited during weekly skin review, quarterly interdisciplinary resident review and admission/yearly clinical health assessment or change of condition. This will monitored by our QAPI committee monthly meetings for 6 months then quarterly times 2, then as needed for any track or trending.</p> <p>Date the systemic changes will be completed: 8/25/15</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>were not limited to...Soft towel placed between chin and chest for pressure relief..."</p> <p>A progress note dated 6/4/15 at 9:22 A.M., indicated, "Situation: Open area under left side of chin Background: Resident keeps chin down most of time making it difficult to see area or keep skin to skin contact from happening. Assessment Area 2 x 2 .2 cm (centimeter) with redness surrounding area approx [approximately] .3 cm Entire red area hard to touch. Wound bed yellow in appearance. No active drainage noted, no odor noted..."</p> <p>A WOUND EVALUATION FLOW SHEET initiated on 6/4/15, indicated a pressure ulcer measured as 2 x 2 x 0.2 cm stage 2 area. Current treatment listed on the Wound Evaluation Flow Sheet was Bactroban (antibiotic ointment) x 14 days and an antibiotic medication of Clindamycin 150 mg (milligrams) x 10 days.</p> <p>A WOUND EVALUATION FLOW SHEET dated 6/18/15, indicated the pressure sore area was a stage 2 which measured 1.8 x 1.8 x 0.2 cm. The Wound Evaluation Flow Sheet indicated the Bactroban ointment and Clindamycin (antibiotic) treatment had been</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>completed.</p> <p>A WOUND EVALUATION FLOW SHEET dated 6/25/15, indicated the pressure sore was a stage 3 with a measurement of 1.2 x 1.2 x 0.2 cm. The Wound Evaluation Flow Sheet indicated no current treatment for the pressure area.</p> <p>A progress note dated 6/30/15 at 2:44 P.M., indicated, "new order for Bactroban oint [ointment] to chin BID [twice a day] for 10 days to open area."</p> <p>A WOUND EVALUATION FLOW SHEET dated 6/30/15 indicated a current treatment of Bactroban and on 7/1/15 a mepilex (dressing) to cover.</p> <p>A progress note dated 7/1/15 at 10:00 A.M., indicated, "New tx [treatment] order received for area on underside of chin... Resident encouraged to keep chin up but does not cooperative [sic] keeps chin on chest most of time."</p> <p>A progress note dated 7/2/15 at 1:58 P.M., indicated, "Mepilex intact to chin as ordered. Resident continues to keep chin down on upper chest. Soft towel placed between chin and chest for pressure relief."</p> <p>A progress note dated 7/6/15 at 10:39</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>A.M., indicated, "Resident was started on hospice services..."</p> <p>A WOUND EVALUATION FLOW SHEET dated 8/5/15 indicated the pressure sore was a stage 3 and measured 1 x .5 x .2 cm. The current treatment listed was skin prep.</p> <p>On 8/6/15 at 8:31 A.M., Resident #40 was observed in bed, with her head flexed forward and a folded wash cloth between the chin and chest area. The pressure sore on her chin was open and observed to be approximately 0.5 cm, with no redness or drainage noted.</p> <p>On 8/6/15 on 9:05 A.M., the CNA (Certified Nursing Assistant) assignment sheet for Resident #40 was received and reviewed. The assignment sheet indicated it had been updated on 5/28/15. The documentation included, but was not limited to, "... each shift-keep cloth under chin for padding."</p> <p>On 8/6/15 at 3:02 P.M., LPN #10 was interviewed regarding Resident #40's chin pressure sore. LPN #10 indicated Resident #40 had neck and hand contractures on admission to the facility. LPN #10 indicated the towel used as a pressure relieving device was "helping a little."</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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F 0319 SS=D Bldg. 00	<p>On 8/7/15 at 9:50 A.M., Resident #40 was observed in bed on her back with her neck flexed forward with chin resting on chest. No padding was observed between her chin and chest area.</p> <p>The policy and procedure for Pressure Ulcers was requested on 8/7/15 at 11:47 A.M., but was not provided.</p> <p>On 8/7/15 at 3:07 P.M., the Director of Nursing (DON) was made aware of the problem of Resident #40 developing a pressure sore on her chin after admission to the facility. The DON at that time, indicated Resident #40 had the neck contraction on admission to the facility. The DON was also made aware of the intervention of padding of the neck and chest area had been lacking during observation on 8/4/15 at 11:30 A.M., and 1:25 P.M., and on 8/7/15 at 9:50 A.M.</p> <p>3.1-40(a)(1)</p> <p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>Based on observation, interview, and record review, the facility failed to ensure effective interventions were implemented to prevent a newly admitted resident(Resident #73) from wandering into other resident rooms and displaying other inappropriate behaviors toward residents on a secured dementia unit.</p> <p>Findings include:</p> <p>On 8/4/15 at 11:54 A.M., Resident #73 was observed sitting at a dining room table on the secured unit with no distress noted.</p> <p>On 8/4/15 at 3:15 P.M., Resident #73's clinical record was reviewed. Resident #73 had been admitted to this facility on 4/2/15. His diagnoses included, but were not limited to, toxic encephalopathy, depressive disorder, and dementia with behavioral disturbances.</p> <p>His admission Minimum Data Set assessment (MDS) dated 4/10/15, indicated supervision of staff and set up help only for bed mobility, walk in room, and walk in corridor. Supervision of staff and the assistance of one staff was needed for transfers. The MDS indicated a cognition summary score of 3, which indicated severe cognitive impairment. The current MDS dated 7/20/15 was a change in condition assessment. The</p>	F 0319	<p>F319D</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #73 was admitted for mental or psychosocial treatment at Transitions on 7/2/15 to 7/13/15. Resident returned with new diagnosis and medication changes. Resident #73's wandering and inappropriate behaviors towards other residents has decreased in frequency and scope since return from hospital and medication adjustments made. No residents have complaints or concerns with his decreased wandering.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>Residents with potential of wandering have the potential to be affected by this deficient practice. No other residents were identified for wandering in other resident rooms or displaying in inappropriate behavior. DNS or designee will review progress notes 5 times weekly during facility start up meeting for any identified behaviors</p>	08/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>assessment indicated supervision of one staff and the assistance of one staff for transfers and walking in room. Supervision of staff and no set up or physical assistance needed for walking in corridor. The 7/20/15 MDS also indicated a cognitive summary score of 3.</p> <p>A care plan dated 4/3/15 addressed the problem of at risk for wandering into other residents rooms. Interventions included, but were not limited to, "Attempt interventions before my behaviors begin...Help me to avoid situations or people that are upsetting to me...Offer me something I like as a diversion..."</p> <p>A care plan problem of elopement had been initiated on 4/3/15. Interventions included but were no limited to, "Check my Wanderguard every shift for placement/malfunction...Find something on the unit I would like to do to divert my attention from the door..."</p> <p>A care plan initiated on 6/10/15 addressed the problem of wandering into other resident rooms and becoming agitated and yelling and raising his fist. Interventions included but were not limited to, "15 minute checks or 1 on 1 if indicated...Do not seat me around others who disturb me...Offer me something I</p>		<p>and proper interventions were initiated. Care Plans will be reviewed and updated for behaviors 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:</p> <p>DNS or designee will review progress notes 5 times weekly during facility start up meeting for any identified behaviors and proper interventions were initiated. Care Plans will be reviewed and updated for behaviors as needed. Social Service Director will continue to monitor 5 times weekly for any display of inappropriate behaviors.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>DNS or designee to review progress notes 5 times weekly during facility start up meeting for any identified behaviors and proper interventions were initiated. Care Plans will be reviewed and updated as needed. This will be monitored during the facility monthly QAPI meeting for 6 months then quarterly times 2, than</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>like as a diversion..."</p> <p>The care plan problem of wandering into other rooms and lying in bed with "other resident" was addressed on 7/2/15. Interventions included but were not limited to, "15 minute checks/1 of 1 if indicated, As a diversion, offer me something else I like...If I display inappropriate behavior, quietly attempt to re-direct, reminding me that the behavior is not appropriate..."</p> <p>The following progress notes were reviewed:</p> <p>4/3/15 at 11:36 A.M., indicated, "...Resident is confused to place, situation, time, season. Can't recall his age, dob [date of birth] of birth or wifes name (sic). Resident is up ad lib. Does have a wonderguard due to his wondering, exit seeking. Resident noted to be exit seeking last evening and during the night, but was easily redirected and was cooperative..."</p> <p>4/3/15 at 6:52 P.M., indicated, "...Pt [patient] has wandered into other residents rooms several times, but is easily redirected..."</p> <p>4/5/15 at 9:13 A.M., indicated, "Resident noted yesterday and evenings to have</p>		<p>as needed for track and trending.</p> <p>Date the systemic changes will be completed: 8/25/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>episodes of wondering [sic]. Had episode of wondering [sic] into other rooms. No reports of the wondering affecting other residents. Resident has been cooperative with redirection. Behavior tracking in place. Care plan updated on interventions today."</p> <p>5/2/15 at 8:56 P.M., indicated, "...will move from his bed to another bed that is empty..."</p> <p>5/5/15 at 9:53 A.M., indicated, "Resident up wandering in hall and in others rooms..."</p> <p>6/9/15 at 8:02 P.M., indicated, "Resident has entered the room of a female resident [Resident #4] x 2 this shift. On first incident at approximately 3:30 PM, female resident yelled at him to leave. [Resident #73] yelled back and shook his fist at her -- note that resident was across the room from female resident. [Resident #73] was immediately redirected and placed on 15 minute checks. [Resident #73] had been in his room when staff was giving care else where and again entered the same female resident's room. Female resident yelled at him to leave and [Resident #73] yelled back at her. He was again redirected..."</p> <p>6/22/15 at 3:32 P.M., indicated,</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>"Resident wandering in to another resident room, the other resident [Resident #63] became agitated et told him he was in the wrong room. Family was present with other resident et stated that this resident became aggressive raising fist. Family redirected this resident et [and] he left room. Staff called to room, residents separated et this resident [Resident #73] placed on 15 min [minute] checks..."</p> <p>6/23/15 at 3:01 A.M., indicated, "Has been OOB [Out Of Bed] x 1, wandered into room across hall, immediately redirected back to his room..."</p> <p>6/30/15 at 11:00 A.M., indicated, "This resident [Resident #73] was standing at the entrance to unit when a female resident [Resident #63] re-entered unit with a staff member. When this resident noticed her, he shook his right fist toward her and mumbled something this nurse was unable to understand and walked briskly down hall toward his room. Several instances in the past have proved this resident appears to be angry when he has eye contact with a particular female resident. Staff ensures that these residents are kept at a distance from each other d/t [due to] an obvious dislike of the two..."</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>7/1/15 at 9:15 P.M., indicated, "Resident found in bed with a female resident [Resident #27]. Lying above blankets, arm around female resident. Staff immediately intervened, resident resistant at first, but agreed to get up. Residents immediately separated...Resident started on one on one with staff..."</p> <p>7/2/15 at 12:46 P.M., indicated "Patient left via[by] [name of] ambulance service to [name of hospital unit] behavior unit..."</p> <p>7/15/15 at 8:53 A.M., indicated, "Resident was readmitted from [name of] mental health unit on 7/13/15 to acu [name of secured unit] and the same room. Remains full code. Resident readmitted with new diagnosis of Psychosis, Dementia with behavior disturce [sic]. Resident was readmitted on Ambien [hypnotic medication] 5 mg [milligram] HS [bedtime], Ativan [antianxiety medication] 1 mg HS, Zoloft [antidepressant] 25 mg QD [every day], Seroquel [antipsychotic medication] 50 mg TID [three times a day]...No inappropriate behaviors noted with other residents..."</p> <p>7/22/15 at 6:50 P.M., indicated, "Was found by staff lying on top of covers of another resident's bed with a different</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>female resident [Resident #67]. Both residents were fully clothed but in an embrace. No intimate behavior, including kissing displayed. Easily redirected from room and went to his own room. Placed on 15 min [minute] checks..."</p> <p>7/28/15 at 8:15 P.M., indicated, "CNA [Certified Nursing Assistant] reported to this nurse she had just witnessed res. [resident] put his arm around a female [Resident #69] who had just sat down next to him on a couch in hall, he then kissed this peer on cheek, CNA approached, redirected them both..."</p> <p>On 8/6/15 at 1:51 P.M., the Social Service Director (SSD) was interviewed regarding Resident #73's inappropriate behaviors. The SSD indicated Resident #73 had been up ad lib (walking independently) with a wanderguard since admission to the facility. She indicated admission care plans had addressed the behaviors of wandering and elopement. She indicated in regard to Resident #73 entering a resident room x 2 on 6/9/15 a stop sign had been placed on the female resident's door and a sensor device. On 6/22/15 when resident entered a resident room and raised his fist, 15 minute checks had been started. She indicated Resident #73 had been placed on one to</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>one monitoring after 7/1/15 when resident was found in bed with a female resident until he was transported to the behavioral hospital unit. SSD indicated Resident #73 returned to facility on 7/13/15 with new psychotropic medications. The SSD indicated 15 minute checks utilized in regard to 7/22/15 when resident was found in bed with another female resident and on 7/28/15 when Resident #73 placed his arm around a female resident and kissed her cheek.</p> <p>During interview with Resident #73's nurse, LPN #9 on 8/7/15 at 9:30 A.M., indicated Resident #73 was a wanderer and continues to wander. She indicated staff continues to monitor Resident #73 closely.</p> <p>On 8/7/15 at 2:11 P.M., the Administrator was made aware of the lack of adequate supervision and effective interventions to address the problem of Resident #73's inappropriate behavior toward other residents which had continued after treatment at a behavioral health hospital unit.</p> <p>3.1-43(a)(1)</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
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F 0431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to store medications in recommended temperature ranges and dispose of</p>	F 0431	F431D	08/25/2015			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>medications per recommended expiration dates for 1 of 2 randomly observed medication refrigerators and 1 of 2 randomly observed medication carts reviewed. (Resident #13, Resident #73, Resident #67)</p> <p>Findings include:</p> <p>1. On 8/7/15 at 1:21 P.M., the secured Alzheimer's Care Unit (ACU)'s medication refrigerator was observed with LPN #9. A Daily Temperature Log sheet posted on the ACU refrigerator indicated, "...Refrigerator Temp [temperature] Range: 36-46 degrees [Fahrenheit]..." LPN #9 indicated the thermometer inside the refrigerator measured 34 F. The refrigerator contained, but was not limited to the following medications: An unopened Levemir (insulin) flex pen for Resident #13, a unopened vial of Humalog insulin for Resident #73, and a opened Apisol (Tuberculosis skin test) injection vial with an open date of 5/5/15 documented step) and a documented 2nd step date of 6/16/15. LPN # 9 indicated the Apisol vial should be discarded due to open date greater than 30 days. LPN #9 also indicated she was unable to determine if the Levemir flex insulin flex pen was</p>		<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Expired medication was removed and destroyed immediately. Replacement of medication was ordered/delivered. Temperatures of refrigerator was adjusted to proper range.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents have the potential to be affected by this deficient practice. Medication refrigerators will be monitored weekly to ensure there are no expired medication. Refrigerator temperatures will be monitored twice daily to ensure proper compliance with regulations.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>DNS or Designee will monitor Medication refrigerators weekly to ensure there are no expired medication. DNS or Designee will</p>	

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	<p>frozen.</p> <p>2. On 8/7/15 at 1:31 P.M., the medication cart on the ACU unit was observed with LPN #9. The medication cart included, but was not limited to the following medications: an opened Humalog insulin 10 ml vial for Resident #67. The open date documented on the vial was 6/2/15. LPN #9 indicated at that time the insulin was out dated.</p> <p>On 8/7/15 at 3:05 P.M., the Director of Nursing (DON) was made aware of medication refrigerator temperature on ACU measuring 34 F and unopened insulin Levemir and Humalog present and Apisol with open date of 5/5/15. The ACU medication cart also container an open Humalog insulin vial with an open date of 6/2/15. On 8/7/15 at 3:07 P.M., the DON indicated, she had consulted with the pharmacy regarding the above medications. The DON indicated, the pharmacist had indicated to discard the insulins due to refrigerator temperature was too cold. The DON also indicated all 3 residents would receive new insulin due to pharmacy recommendations. The DON indicated the medication refrigerator temperature on the ACU had been readjusted.</p>		<p>monitor Refrigerator temperatures twice daily to ensure proper compliance with regulations. Nursing staff in-serviced on destruction of expired medications and appropriate temperature range of refrigerator and process of temperature outside of range.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>DNS or Designee will monitor Medication refrigerators weekly to ensure there are no expired medication. DNS or designee will monitor Refrigerator temperatures twice daily to ensure proper compliance with regulations. This will be monitored by the QAPI monthly meeting times 6 months, then quarterly times 2, then as needed for track or trends.</p> <p>Date the systemic changes will be completed: 8/25/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
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	<p>On 8/7/15 the facility policy entitled, "Medication Storage in the Facility, Storage of Medications (Policy Revised November 2011)" was received and reviewed. The policy included but was not limited to, "...Temperature C. Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 degrees C [Celsius] (36 degrees F[Fahrenheit]) and 8 degrees C (46 f degrees F)' with a thermometer to allow temperature monitoring..."</p> <p>"E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a 'date opened' sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a 'date opened ' and 'expiration' notation line). The expiration date of a vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating..."</p> <p>3.1-25(m) 3.1-25(o)</p>			