

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
---	--

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

F 000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00171883 and IN00173677.</p> <p>Complaint IN00171883 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00173677 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314.</p> <p>Survey dates: May 19 and 20, 2015.</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Census bed type: SNF/NF: 102 Total: 102</p> <p>Census payor type: Medicare: 5 Medicaid: 84 Other: 13 Total: 102</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3-1.</p>	F 000		
-----------------------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
---	--

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

F 314 SS=D Bldg. 00	<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, interview and record review, the facility failed to ensure a resident with pressure areas received weekly skin assessments for 2 of 3 residents reviewed for pressure ulcers (Residents B and E).</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident B was reviewed on 5/19/15 at 10:23 a.m. Diagnoses for the resident included, but were not limited to, quadriplegic, neurogenic bladder, depression, diabetes, hypertension, congestive heart failure and coronary artery disease.</p> <p>A Care Management Meeting Note, dated 3/25/15, indicated Resident B was admitted to the facility with multiple wounds. Measurements from 3/23/15 indicated the following wounds: left heel</p>	F 314	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides at the facility. Resident E had the skin integrity documentation reviewed for completeness. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents with acquired or admitted wounds had weekly documentation reviewed to ensure measurements were included in the description of the wound. Residents had their weekly general skin integrity assessments, day and time determined by shower schedule, reviewed for completion. Any corrective actions needed were made at this time. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p>	06/19/2015
---------------------------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/20/2015	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE				STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>stage 3, 4.5 cm x 4.0 cm x 0.3 cm, right heel stage 3, 4.5 cm x 5.0 cm x 0.1 cm, right trochanter stage 4, 16 cm x 13.5 cm x 1.5 cm, coccyx 11.0 cm x 8.0 cm x 1.0 cm, left ischium 6.0 cm x 5.5 cm x 0.5 cm and right trochanter 9.0 cm x 6.0 cm x 1.0 cm.</p> <p>Resident B was being followed by a wound center. Measurements were obtained from the wound center again on 3/31/15. Resident B was seen at the wound center on 4/14/15, 5/7/15 and 5/12/15. Resident B had a wound Vacuum Assisted Closure (VAC) on admission to the coccyx, bilateral hips and left buttock. Resident B was receiving multiple treatments to each wound. Resident B was also receiving intravenous (IV) antibiotics for sepsis on admission. The IV antibiotics and Peripherally Inserted Central Catheter (PICC) line was discontinued on 5/8/15 following an appointment at the wound center.</p> <p>The Braden scale indicated, on 3/13/15, Resident B scored a 9, indicating severe risk for developing a pressure ulcer.</p> <p>A Physician's Order, dated 3/13/15, indicated weekly skin reviews to be done.</p> <p>During review of the Wound Evaluation</p>		<p>Education provided to nursing staff regarding day and time of weekly skin integrity assessments and proper completion of documentation. Unit Manager, or designee, will review shower schedule in morning clinical start up to ensure documentation is present and complete. DNS, or designee, will review weekly wound assessment documentation to ensure measurements are included in the description of the wound.4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?Results of audits will be reviewed in QAPI for 6 months and then thereafter as needed for compliance. A Process Improvement Plan will be revised as needed during the review period based on patterns and/or trends.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/20/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Flow Sheets, the last recorded measurement of the left and right heel was done on 4/6/15. The last recorded measurement of the left inner buttock, right trochanter and left trochanter was done on 3/31/15 by the facility.</p> <p>Resident B's Health Care Plan, initiated on 3/13/15, indicated, "Pressure ulcer actual or at risk due to...." The interventions indicated, "Braden scale...weekly skin inspections...."</p> <p>During review of the March, April, and May, 2015 Medication Administration Record (MAR) and Treatment Administration Record (TAR), Resident B received medications and treatments as ordered.</p> <p>Resident B was sent to the hospital on 5/12/15 following a wound visit. Review of the hospital records indicated a final consultation note indicated the wounds all looked clean and granulating.</p> <p>2. The clinical record of Resident E was reviewed on 5/20/15 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, depression, morbid obesity, debility, congestive heart failure and anxiety. Resident E was admitted to the facility with a right heel wound.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An undated Braden scale indicated Resident E scored a 17, indicating risk for developing a pressure ulcer.</p> <p>A Physician's Order indicated "weekly skin review."</p> <p>Resident E's Health Care Plan, initiated on 11/3/14, indicated, "Pressure ulcer actual or at risk due to...." The interventions indicated, "conduct weekly skin inspections...heel boots...Braden scale..."</p> <p>Review of the Initial Pressure Ulcer Assessment, dated 10/31/14, indicated a right heel pressure wound that measured 4.5 cm. x 4.0 cm x 0.5 cm. The wound was listed as an arterial wound, but a wound VAC was in place. The most recent measurement was completed on 4/13/15. The wound measured 1.5 cm x 2.5 cm x 0.2.</p> <p>During wound care observation on 5/20/15 at 9:35.m., Resident E was observed in bed in a supine position with a heel boot on. LPN #1 washed her hands then donned disposable gloves. LPN #1 removed the old dressing that was dated 5/19/15. The wound bed appeared red/pink in color. The wound was shallow in depth and did not have any slough. LPN #1 washed her hands</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/20/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>again and donned gloves. LPN #1 then applied a thick layer of Santyl (topical ointment for wound care) with a cotton tip applicator. The wound was then covered with foam dressing and wrapped with gauze as ordered.</p> <p>During review of the March, April, and May, 2015 Medication Administration Record (MAR) and Treatment Administration Record (TAR), Resident E received medications and treatments as ordered.</p> <p>During an interview on 5/20/15 at 3:00 p.m., the Assistant Director of Nursing (ADON) indicated the previous Director of Nursing (DON) over saw the wounds in the facility. She indicated the DON met with the unit managers weekly to review the wounds and skin sheets. She indicated the DON no longer worked at the facility and had been gone since the first week of April.</p> <p>Review of a current undated facility policy titled "Golden Clinical Services / Skin Integrity Guideline", which was provided by the ADON on 5/20/15 at 12:30 p.m., indicated the following:</p> <p>"...Documentation of Weekly Skin Evaluation/Observations: Licensed nurse...a skin evaluation/observation</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  05/20/2015
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>weekly...document weekly on identified wounds...."</p> <p>This federal tag relates to Complaint IN00173677.</p> <p>3.1-40(a)(2)</p>				