

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 12/17/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
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F000000	<p>This visit was for the Investigation of Complaint IN00159662.</p> <p>Complaint IN00159662 Substantiated. Federal/State deficiency related to the allegations is cited at F514.</p> <p>Survey dates: December 16 and 17, 2014</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 108 Total: 108</p> <p>Census payor type: Medicare: 7 Medicaid: 80 Other: 21 Total: 108</p> <p>Sample: 3</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.-3.1.</p>	F000000	F000 This Plan of Correction constitutes my written allegation of compliance for the deficieincy cited. However, the Plan of Correction is not an admission that a deficiency existed or that one was cited correctly. The Plan of Correction is being submitted to meet requirements of state and federal law. Based on ISDH surveyor recommendation, Golden Living Center respectfully requests a paper compliance review for the Plan of Correction.	

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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F000514 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented in regards to fall interventions in place at the time the falls occurred for 1 of 3 residents reviewed for complete and accurate clinical record documentation in a sample of 3. (Resident #B)</p> <p>Findings:</p> <p>The clinical record for Resident #B was reviewed on 12/16/14 at 10:30 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease,</p>	F000514	Resident #B has no residual injuries from the two falls identified. He remains in a chair and ambulates with two person assist. He continues to have the chair and bed alarm. It is on and functioning. The Post Fall Analysis/Plan identified that adaptive devices were in place and used. The alarm was sounding at the time of both occurrences. The Post Fall Analysis/Plan is a part of the medical record. Other residents who have had falls are currently being audited for inclusion of interventions in place at the time of the fall and documented in the nursing progress notes. Nurses were educated on 12/22 and	12/31/2014			

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	<p>chronic kidney disease, diabetes mellitus, and dementia with behavioral disturbances.</p> <p>A recapitulation of physician's orders, dated 10/14/14, indicated Resident #B had an order for "Bed alarm/chair alarm on at all times to alert staff of attempts of unassisted transfers". The original date of this order was 6/27/14.</p> <p>A nursing note, dated 9/6/14 at 2:14 p.m., indicated the resident had been found on the floor of his room next to his bed. The note contained assessment information and physician and family notification information.</p> <p>The clinical record lacked any information related to whether a bed or chair alarm was sounding when the resident was found on the floor.</p> <p>The DON was interviewed on 12/17/14 at 9:25 a.m. in regards to the fall occurring on 9/6/14. She indicated she had reviewed the 9/8/14 "Stand up meeting" notes related to the fall on 9/6/14. She indicated those notes indicated all interventions were in place at the time of the fall, but did not list the interventions separately. She indicated the "Stand up meeting" notes were not part of the clinical record.</p>		12/23/14 on the need to include in the progress note what interventions were in place at the time of the incident. DNS or designee will monitor for compliance by review of all Post Fall Analysis/Plans with nursing progress notes on the next day following the occurrence. This will be an ongoing process. Any patterns or trends will be reviewed in QAPI.				

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	<p>A nursing note, dated 11/15/14 at 10:36 a.m., indicated "Res [resident] in dining room, got up from wheelchair and walked across dining room to entry of dining room where he fell hitting his head above the left eye..." The note contained assessment information and family and physician notification information.</p> <p>The clinical record lacked any information related to whether the resident's chair alarm had sounded when he got up from his chair without assistance in the dining room.</p> <p>The DON was interviewed on 12/16/14 at 3:35 p.m. in regards to the fall occurring on 11/15/14 (a Saturday). She indicated she did remember being called related to this fall and the staff had indicated the resident's alarm was sounding at the time of the fall. This information was not part of the clinical record.</p> <p>Review of the current facility policy, dated 11/13/14, provided by the DON on 12/17/14 at 11:15 a.m., titled "Falls Change of Condition Guidelines for Completion", included, but was not limited to, the following:</p> <p>"Guidelines statement: To assess</p>						

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	<p>individual conditions after a fall occurs and to identify the reason and/or risk factors for the fall in order to prepare a plan of care to reduce the potential for future falls.</p> <p>...Procedure:</p> <p>If a resident falls...</p> <p>...2. The licensed nurse shall initiate the Change of Condition Report-Post Fall Investigation Summary. This shall be kept in the resident's medical record....</p> <p>....Interventions used prior to fall: Identify all interventions implemented prior to the fall occurring...."</p> <p>This federal tag relates to Complaint IN00159662.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				