

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 11/20/2013
--	---	--	---

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
F000000	<p>The visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00139385.</p> <p>Survey dates: November 14, 15, 18, 19, 20, 2013</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Survey Team: Karen Lewis RN, TC Ginger McNamee, RN Betty Retherford, RN (November 15, 18, 19, 20, 2013) Tina Smith - Staats, RN Jason Mench, RN (November 14, 15, 18, 2013) Angela Selleck, RN (November 19, 20, 2013)</p> <p>Census bed type: SNF/NF: 94 Total: 94</p> <p>Census payor type: Medicare: 5 Medicaid: 69 Other: 20</p>	F000000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/20/2013
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>Total: 94</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</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 11/20/2013
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	
F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of weight gain in accordance with his orders for 1 of 5 residents reviewed for unnecessary</p>	F000157	F-157 It is the policy of this facility to provide notification to resident's physician and responsible party as directed by physician orders and with any change of condition that is noted.	12/20/2013	

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 11/20/2013	
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>medications. (Resident #73)</p> <p>Findings include:</p> <p>The clinical record for Resident #73 was reviewed on 11/18/13 at 1:09 p.m.</p> <p>Diagnoses for Resident #73 included, but were not limited to, diabetes, hypertension, congestive heart failure, and chronic kidney disease.</p> <p>A physician's order, dated 8/18/13, indicated Resident #73 was to be weighed daily. The physician was to be notified if the resident had a weight gain of 2 pounds daily or a 4 pound weight gain weekly.</p> <p>Review of the September, October, and November, 2013 Treatment Administration Records (TARs) indicated the following daily weights:</p> <p>9/7/13 - 178 pounds (lbs.) and 9/8/13 - 183 lbs., a weight gain of 5 lbs. 9/12/13 - 174.8 lbs. and 9/13/13 - 183 lbs., a weight gain of 8.2 lbs. 9/16/13 - 174.8 lbs. and 9/17/13 - 183 lbs., a weight gain of 8.2 lbs. 9/22/13 - 174.8 lbs. and 9/23/13 - 182 lbs., a weight gain of 7.2 lbs. 10/16/13 - 172 lbs. and 10/17/13 - 174.4 lbs., a weight gain of 2.4 lbs.</p>		<p>Resident #73 chart was reviewed under the direction of the Director of Nursing for other changes of condition. All other physician orders and changes in condition had physician and family notification. All other residents will have charts reviewed under the direction of the Director of Nursing by 12/18/2013, for physician orders and change in conditions to ensure that physician and responsible party notification was complete. To enhance currently compliant operations and under the direction of the Director of Nursing, on 12/19/2013, licensed nursing staff will receive in-service training regarding state and federal requirements for physician and responsible party notification by the Director of Clinical Education with emphasis of nursing documentation of notification in the nurses notes. On 12/19/2013, a quality assurance program will be implemented under the supervision of the director of nurses to monitor notification of physician orders and change of conditions in all residents. The Director of Nursing or nursing designee will audit chart for proper physician and family notification for physician orders and changes of condition five times a week for four weeks, then three times a week for four weeks then once a week for four weeks.</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 11/20/2013	
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>10/26/13 -168.4 lbs. and 10/27/13 - 171 lbs., a weight gain of 2.6 lbs. 11/4/13 - 169 lbs. and 11/5/13 - 173.4 lbs., a weight gain of 4.4 lbs.</p> <p>The clinical record lacked any documentation of the physician having been notified of the daily weight gains for Resident #73 on 9/8/13, 9/13/13, 9/17/13, 9/23/13, 10/17/13, 10/27/13, and 11/5/13.</p> <p>During an interview with RN #7 (Skilled Unit Manager) on 11/20/13 at 9:28 a.m., she indicated the clinical record lacked any documentation of the physician having been notified of Resident #73's daily weight gains on 9/8/13, 9/13/13, 9/17/13, 9/23/13, 10/17/13, 10/27/13, and 11/5/13. She further indicated the physician should have been notified of the resident's weight gains.</p> <p>The May 2001 policy for "Weight and Height Measurement" was provided by the Administrator on 11/20/13 at 12:40 p.m. The policy indicated:</p> <p>"...Purpose: The purpose of taking weight and height measurement is to: ...Note: Residents are weighed on admission and monthly unless otherwise ordered by nursing order or the attending physician to monitor the resident's condition. Resident's</p>		Any deficiencies will be corrected on the spot, and the findings of the of the quality assurance checks will be documented and submitted at the monthly quality assurance meeting for further review or corrective action.				

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 11/20/2013
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>height is measured on admission.</p> <p>Assessment: General guidelines for assessment may include, but are not limited to: ...Diuretic use...."</p> <p>The undated policy for "Notification of Change in Resident Health Status" was provided by the Administrator on 11/20/13 at 2:37 p.m. The policy indicated:</p> <p>"The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is: ...(C) A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</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 11/20/2013	
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			
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 record review and interview, the facility failed to ensure interventions identified in the resident's plan of care were completed after a fall for 1 of 3 residents reviewed for falls (Resident #73) and failed to ensure laboratory tests were obtained as ordered by physician for 1 of 5 residents reviewed for unnecessary medications. (Resident #73)</p> <p>Findings include:</p> <p>1.a. The clinical record for Resident #73 was reviewed on 11/18/13 at 1:09 p.m.</p> <p>Diagnoses for Resident #73 included, but were not limited to, diabetes, hypertension, congestive heart failure, and chronic kidney disease.</p> <p>A health care plan problem, dated 8/24/13, indicated Resident #73 was at risk for falls related to falls in past 30 days. Interventions for this problem included "Assess that wheel chair is of appropriate size; assess</p>	F000282	<p>F-282 It is the policy of this facility to follow resident's care plan as directed. Resident 73 care plan was reviewed to ensure that all interventions were appropriate and being followed as approved by the Interdisciplinary Team. No other issues were identified. Resident # 73 no longer reside in the facility. All other residents will have their care plans reviewed, under the direction of the Director of Nursing, by 12/18/2013, to ensure that each resident has the appropriate safety devices and labs in place and that care plans are being followed. To enhance currently compliant operations and under the direction of the Director of Nursing, on 12/19/2013, nursing staff will receive in-service training regarding state and federal requirements for ensuring that all residents will have the care plans carried out as directed with an emphasis on safety devices and labs will be followed by the Director of Clinical Education. On 12/19/2013, a quality assurance program will be implemented under the supervision of the Director of Nursing to monitor for following care plan interventions. Ten care plans will be reviewed</p>	12/20/2013			

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 11/20/2013	
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>need for footrests; assess for need to have wheelchair locked/unlocked for safety, anti tippers." Date intervention initiated was 11/5/13.</p> <p>The clinical record lacked any documentation of the wheelchair assessments.</p> <p>During an interview with Medical Records Staff #2 on 11/20/13 at 8:10 a.m., additional information was requested related to a wheelchair assessment for Resident #73.</p> <p>During an interview with the acting Director of Nursing on 11/20/13 at 11:00 a.m., she indicated therapy usually completes the assessments. She further indicated she did not know of any other staff completing the assessments for wheelchairs or other resident equipment.</p> <p>During an interview with the acting Director of Nursing on 11/20/13 at 11:18 a.m., she indicated she had no documentation of an assessment of the wheelchair for Resident #73 to provide.</p> <p>1.b. Resident #73 had current physician orders including the following, but not limited to:</p>		<p>on a weekly basis for four weeks, then five care plans reviewed on a weekly basis x 4 weeks with emphasis on fall interventions and labs with deficiencies corrected, and the results reported to the quality assurance committee meeting for further review or corrective action.</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 11/20/2013
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>A one time only physician telephone order for a Hemoglobin A1C (a blood glucose laboratory test). The original date of this order was 9/10/13.</p> <p>A telephone order for hemoccult stools (test to check for blood in the stool) times two. The original date of this order was 9/25/13.</p> <p>The clinical record lacked any results for the Hemoglobin A1C and the hemoccult stool results ordered by the physician for Resident #73.</p> <p>During an interview with the acting Director of Nursing on 11/20/13 at 11:00 a.m., additional information was requested related to the Hemoglobin A1C and hemoccult stool results for Resident #73.</p> <p>During an interview with the acting Director of Nursing on 11/20/13 at 11:18 a.m., she indicated she had no results to provide for the Hemoglobin A1C or the hemoccult stool tests. The revised 2013, "Lab Processing/Tracking Guidelines" was provided by the Nurse Clinical Educator on 11/20/13 at 2:53 p.m. The guidelines indicated:</p> <p>"Purpose: Diagnostic tests are processed, ordered, obtained and</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 11/20/2013
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>performed and that results are received timely. Test results are communicated to the physician in a timely manner with documentation present in the medical record..."</p> <p>The revised 2013, "Falls Management Clinical Guidelines" was provided by the Acting Director of Nursing on 11/20/13 at 2:34 p.m. The guidelines indicated:</p> <p>"...The interdisciplinary team evaluates the fall prevention plan of care for residents "at risk" for falls. (e.g. Review Methods: Grand Rounds, Daily Stand-up or Risk Committee). This evaluation may include a screening by a rehabilitation services representative and pharmacy consultant for medications that could affect balance or gait...</p> <p>...Following a resident's fall: ...Appropriate interventions are implemented. Care plan is updated...</p> <p>...Monitoring Compliance: The following elements are in place for the center to demonstrate satisfactory compliance with the guide: ...Residents at risk for falls are care planned with individualized interventions...</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 11/20/2013
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>...Post Fall Investigation Summary: Guidelines for Completion: ...Recommendations and interventions Post Fall: Identify any new interventions that will be immediately implemented to reduce the potential for falls to reoccur. Attain any physician order or resident consent per facility policy.</p> <p>...The Interdisciplinary Care Plan team will complete a review of the Post Fall Investigation. This will be completed within 72 hours. Recommendations implemented shall be recorded on the report and plan of care revised as necessary...."</p> <p>3.1-35(g)(2)</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 11/20/2013
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	
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the nursing staff provided peritoneal dialysis services using the correct dialysis solution for 1 of 1 dialysis resident reviewed (Resident #D) and failed to ensure rectal tube orders were clarified with the physician to prevent the continued placement of a rectal tube for 1 of 1 resident reviewed who had been admitted with a rectal tube in place. (Resident #C)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #D was reviewed on 11/18/13 at 10:40 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic kidney disease stage 5 with end stage renal disease, coronary atherosclerosis, anemia, and hypertension.</p> <p>Admission orders, dated 10/23/13, indicated the resident was to have</p>	F000309	F-309 It is the policy of this facility to ensure that residents that are receiving peritoneal dialysis will receive the proper solution as directed per the physician orders and that orders for rectal tubes are clarified for diagnosis and use. At this time both Resident # D and Resident # C have been discharged from the facility. At this time, there are no other residents that are receiving peritoneal dialysis or rectal tubes. To enhance currently compliant operations and under the direction of the Director of Nursing, on 12/19/2013, licensed nursing staff will receive in-service training regarding state and federal requirements for ensuring that residents receive proper dialysis solution and continued use for rectal tubes, with emphasis on clarifying and verifying orders as needed by the Director of Clinical Education. On 12/19/2013, a quality assurance program will be implemented under the supervision of the Director of Nursing to monitor residents on peritoneal dialysis or rectal tubes to ensure compliance	12/20/2013	

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 11/20/2013	
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>continuous ambulatory peritoneal dialysis (CAPD) per cycler with exchanges of 17.9 liters of fluid daily. The orders indicated the strength of the dextrose solution would vary based on the resident's blood pressure at the time of the treatment.</p> <p>The admission CAPD order was clarified on 10/24/13 to the following:</p> <p>Peritoneal dialysis per Cyclor machine:</p> <p>Use 1.5 % [dextrose] solution if sbp (systolic blood pressure) less than 110 Use 2.5 % [dextrose] solution if sbp 110-160 Use 4.25% [dextrose] solution if sbp greater than 160</p> <p>Note bp and solution being used. Do every evening and night shift.</p> <p>During an review of the October and November 2013 treatment administration records (TAR) for Resident #D the following concerns were noted:</p> <p>10/25/13 evening shift: Bp 118/68 1.5% solution used- should have been 2.5%</p>		<p>of orders five times a week x four weeks, then three times a week for weeks, then weekly for four weeks with any deficiencies corrected, and the results reported to the quality assurance committee meeting for further review or corrective action.</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 11/20/2013	
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>10/26/13 evening shift: Bp 118/72 1.5% solution used- should have been 2.5%</p> <p>10/26/13 third shift: Bp 120/74 1.5% solution used- should have been 2.5%</p> <p>10/27/13 third shift: Bp 123/70 1.5% solution used- should have been 2.5%</p> <p>11/2/13 evening shift: Bp 110/72 1.5% solution used- should have been 2.5%</p> <p>11/3/13 evening and third shift-no information</p> <p>11/4/13 evening shift (no Bp on TAR) -1.5 % solution used-Nursing note entry of 11/4/13 at 6:40 p.m. indicated the resident's Bp was 150/89. 2.5% solution should have been used.</p> <p>The Acting DoN and RN #7 (the Unit Manager for Resident #D's hall) was interviewed on 11/19/13 at 2:45 p.m. Concerns were addressed related to the wrong solution having been used for the peritoneal dialysis on the above noted dates and times. RN#7 indicated some of the solution used had been brought in from the resident's home and some had been</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 11/20/2013
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>provided by the dialysis center. She indicated the facility had also ordered solution for the resident. She indicated she had no information to provide related to why the wrong solution was documented.</p> <p>A nursing note entry, dated 11/3/13 at 6:03 p.m., indicated LPN #3 had called the on-call physician at that time and an order had been obtained for her to use the 1.5% dextrose fluid thru the cyclor for "tonights" dose only.</p> <p>This was the only entry noted for the dates and times noted above when the wrong dextrose solution was used.</p> <p>LPN #3 was interviewed on 11/20/13 at 11:45 a.m. She indicated she had called the on call physician on 11/3/13 to get an order to use the 1.5% solution because she did not have any 2.5% solution in supply on the unit. She indicated the resident should have received the 2.5% solution based on his blood pressure, but she did not have any to use. She indicated she did not know why nothing was charted on the TAR for that date.</p> <p>The Administrator and Acting DoN</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 11/20/2013
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>were interviewed on 11/19/13 at 2:55 p.m. Information was requested related to the wrong solution of dextrose solution having been used on the dates noted above.</p> <p>The facility failed to provide any additional information related to why the wrong solution was used.</p> <p>2.) The clinical record for Resident #C was reviewed on 11/18/13 at 1:45 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, congestive heart failure, coronary atherosclerosis, chronic kidney disease, acute and chronic respiratory failure with tracheostomy, toxic encephalopathy, and malignant carcinoid tumor of the descending colon .</p> <p>A nursing note entry, dated 11/1/13 at 4:30 p.m., indicated Resident #C was admitted to the facility with a rectal tube, foley catheter, gastrostomy tube, and gallbladder drain in place. The note indicated "resident sometimes opens eyes to physical stimuli; otherwise is unresponsive..."</p> <p>Admission orders, dated 11/1/13, indicated "Maintain rectal tube.</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 11/20/2013
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>Check placement every shift and empty contents of container every shift related to malignant carcinoid tumor of the descending colon."</p> <p>A nursing note entry, dated 11/3/13 at 1:46 p.m., indicated "...rectal tube in place, slight leakage from tubing... will continue to monitor to see if resident needs to be assessed for re-placement of rectal tube... Weekend manager aware of "leakage"...."</p> <p>A nursing note entry, dated 11/4/13 at 1:22 a.m., indicated "... rectal tube in place with stool noted in tubing. Stool noted coming out around tube...."</p> <p>A nursing note entry, dated 11/4/13 at 1:32 p.m. indicated "rectal tube in place, slight leakage from tubing. Resident cleaned up, tubing repositioned and will continue to monitor to see if resident needs to be assessed for re-placement of rectal tube. DON aware of situation with rectal tube leakage and stated would be down to re-insert.</p> <p>The clinical record lacked any other physician's orders related to the rectal tube until 11/5/13 at 3:33 p.m. That order indicated "May discontinue rectal tube." This order was entered</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 11/20/2013	
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>by RN #12.</p> <p>A nursing note entry, dated 11/5/13 at 3:57 p.m., indicated "rectal tube removed per medical doctor order-45 milliliters normal saline obtained from bulb..."</p> <p>RN #7 (the unit manager for Resident #C's unit) was interviewed on 11/19/13 at 10:00 a.m. Additional information was requested related to Resident #C's need for an indwelling rectal tube from 11/1/13 through it's removal on 11/5/13. RN #7 indicated she was unaware Resident #C was being admitted with a rectal tube in place until he was enroute to the facility. She indicated she talked to the dismissing nurse at the hospital when he was enroute to the facility. She was told he had an indwelling rectal tube (a tube inserted into the colon that had a cuff like balloon filled with normal saline to hold the tube in place) that had been placed due to multiple surgeries from colon cancer and was needed to prevent skin breakdown from frequent loose stools. She indicated she had asked the dismissing nurse if the rectal tube could be discontinued after the resident was admitted to the facility. She indicated the hospital nurse told her the resident still needed the tube</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 11/20/2013
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>due to loose stools and the facility just needed to monitor the collection bag and empty it every shift.</p> <p>RN #7 indicated she had written the need for the rectal tube up as an admission order and had not clarified the continued need for the tube with the resident's physician.</p> <p>She indicated the resident's nursing home physician had been contacted on 11/5/13 after the resident began to have stool noted coming out around the tube. She indicated the physician did not know why the tube was needed and he had called the hospital physician related to the need for the rectal tube. She indicated the resident's physician had called the facility back and told them to discontinue the tube. He indicated the resident's rectal tube was supposed to have been discontinued at the hospital prior to transfer to the facility.</p> <p>3.1-37(a)</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 11/20/2013
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	
F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based record review and interview, the facility failed to ensure restorative nursing was provided for one of three residents reviewed for rehabilitation services. (Resident #126)</p> <p>Findings include:</p> <p>Resident #126's clinical record was reviewed on 11/18/13 at 12:30 p.m. The resident's diagnoses included, but were not limited to, aftercare healing traumatic fracture lower arm, anemia, osteoporosis, and Alzheimer's disease.</p> <p>The resident had been admitted with orders for physical therapy. The physical therapy maximum potential was met and the resident was discontinued from therapy. On 10/29/13, a Restorative Nursing Functional Maintenance Plan was developed by therapy for the resident.</p> <p>Review of the Restorative Nursing/Functional Maintenance Plan dated 10/29/13, indicated the resident was to start range of motion and</p>	F000311	F- 311 It is the policy of this facility to provide Restorative Nursing to those residents that require Restorative Nursing Programs. Under the direction of the Director of Nursing, Resident #126 Restorative Nursing Program was reviewed for continued need. Because all residents that are receiving Restorative Nursing are potentially affected by the cited deficiency, on 12/19/2013, the Director of Nursing will review those residents that are currently receiving restorative nursing for appropriateness of program. To enhance currently compliant operations and under the direction of the Director of Nursing, on 12/20/2013 nursing staff will receive an in-service training regarding state and federal requirements for Restorative Nursing protocol. The training will emphasize the importance of the Nursing Restorative Program as indicated on the resident's care plan by the Director of Clinical Education Effective 12/20/2013, a quality assurance program will be implemented under the supervision of the Director of Nursing to monitor the restorative	12/20/2013	

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 11/20/2013
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>walking with restorative nursing. The specific approaches were for the resident to perform active range of motion to bilateral lower extremities 20 repetitions to maintain joint mobility and strength. The resident was to ambulate 50 feet with gait belt and cues followed with a wheelchair as needed for safety.</p> <p>During an interview with the Manager of the Therapy Department on 11/18/13 at 1:10 p.m., she indicated the resident was non-compliant with therapy and refused many treatments. She indicated the resident was discharged to restorative nursing care on 10/29/13.</p> <p>During an interview with Restorative CNA #9 on 11/18/13 at 2:30 p.m., she indicated the resident was not on the Restorative Nursing program. She indicated she had not been notified to start the resident on the program. She indicated the nurse in charge of the Restorative Nursing program had quit and did not obtain the order.</p> <p>The revised 2013, Restorative Guideline for Golden Clinical Services was provided by the Administrator on 11/20/13 at 12:40 p.m. The guideline indicated the facility provided a program with interventions to promote</p>		<p>nursing program. The Director of Nursing or designated quality assurance representative will perform audits on residents receiving Restorative Nursing ten residents per week for four weeks, five residents per week for four week, and then on monthly basis with deficiencies corrected, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action</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 11/20/2013
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>the resident's ability to adapt and adjust to living as independently and safely as possible. The Restorative Nursing Coordinator facilitated communication between the interdisciplinary team and managed the Restorative Nursing program.</p> <p>3.1-37(a)</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 11/20/2013
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	
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 interview, the facility failed to ensure 2 of 3 residents reviewed for pressure ulcer wound care prevention and services received those services in accordance with their plan of care to prevent the development of and/or encourage healing of pressure areas. (Resident #B and #G)</p> <p>Findings:</p> <p>1.) Wound care provided by LPN #11 to Resident #B was observed on 11/20/13 at 11 a.m. The area was above the resident's coccyx/right buttock area. The wound bed was clean. The wound measured 2.5 centimeters (cm) by 3.8 cm with a depth of 3 cm. The treatment was completed per the current order without any concerns noted.</p>	F000314	F314 – It is the policy of this facility to provide treatments as directed for prevention of pressure ulcers. Residents #B and #G orders have been reviewed for administration times and treatment orders. Licensed nurses will be educated on the five rights of medication and treatment administration on 12/19/2013. Because all residents that are receiving treatments are potentially affected by the cited deficiency, on 12/06/2013, the Director of Nursing will review all treatment sheets for all residents having treatments. Under the direction of the Director of Nursing services, licensed nurses were observed for providing treatments at appropriate times as directed per the treatment administration records. Nursing staff was also observed to ensure that devices that are to be utilized to aide in the prevention of pressure ulcers were in place on the residents as ordered. No	12/20/2013	

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 11/20/2013	
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>The clinical record for Resident #B was reviewed on 11/19/13 at 4 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, acute osteomyelitis, diabetes mellitus, iron deficiency anemia, and history of pressure ulcer debridement with surgical flap and ongoing wound treatment.</p> <p>A health care plan problem, dated 10/30/13, indicated Resident #B had a pressure ulcer on his right buttock. One of the interventions for this problem was "Treatments as ordered."</p> <p>A wound clinic order, dated 9/27/13, indicated the resident had been seen at the wound center for pressure wound dehiscence. The clinic order indicated the previous treatment had been discontinued and a new treatment initiated. A physician's order, dated 9/27/13, indicated the new order was for Polymem wic to the wound on the right buttock. The staff were to cleanse the area around the wound bed, but not cleanse the actual wound bed. The staff were to apply Polymem wic to wound bed and cover with Polymem max and apply abdominal gauze and coverall. The staff were to change the dressing</p>		<p>other issues were identified. To enhance currently complaint operations under the direction of the Director of Nursing, on 12/13/2013 nursing staff will receive in-service training regarding state and federal requirements for preventing pressure ulcers with an emphasize of providing treatments at times directed per physician, by the Director of Clinical Education Effective 12/19/2013, a quality assurance program will be implemented under the supervision of the Director of Nursing to monitor treatment administration for accuracy of time completed and appropriate pressure relieving devices, such as bunny boots, twice a week for four weeks then weekly for four weeks, checking residents who require dressing changes or bunny boots as directed per physician orders. Any deficiencies will be corrected, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action.</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 11/20/2013
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>before visible soilage was present as needed. The staff were to not leave the dressing on any longer than 7 days. The wound site was to be monitored every shift. The note indicated the pharmacy was aware.</p> <p>The September and October 2013 treatment administration records (TAR) indicated the staff checked the site every shift, but did not have a method to indicate the exact dates the wound treatment was completed in order to not exceed the 7 day time period.</p> <p>There were no nursing note entries, dated 9/28 or 9/29/13 related to the wound dressing. A nursing note entry, dated 10/2/13 at 11:26 p.m., indicated "Foam dressing and abdominal pad applied per wound center orders." The treatment sheet lacked any information related to this order being completed or why the order was obtained. The physician's orders lacked any information related to this order having been written or how often it was to have been done.</p> <p>LPN #11 was interviewed on 11/20/13 at 1:00 p.m. She indicated the nurse who took the above order was no longer employed by the facility. She indicated that nurse had obtained the</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 11/20/2013
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>order because the resident's dressing was soiled and needed to be changed and they did not have any of the Polymem wic in supply.</p> <p>LPN #11 and RN#10 reviewed the clinical record at that time and were unable to find any order for the treatment ordered on 10/2/13.</p> <p>A nursing note entry, dated 10/3/13 at 3:10 a.m., indicated the nursing staff were "awaiting pharmacy" in regards to the wound treatment.</p> <p>A nursing note entry, dated 10/3/13 at 9:58 p.m., indicated "Dressing to right hip clean, dry, and intact. Awaiting new dressing supplies."</p> <p>A nursing note entry, dated 10/4/13 at 8:49 a.m., indicated "Spoke with [name of staff] at wound center regarding resident's new treatment supplies. Her suggestion was to order the Polymem online. If we can't get it that way, we are to call her back to see what other options may be available."</p> <p>A nursing note entry, dated 10/4/13 at 9:36 p.m., indicated "awaiting pharmacy to deliver."</p> <p>A nursing note entry, dated 10/5/13 at</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 11/20/2013	
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>11:05 a.m., indicated "Waiting pharmacy" in regards to the wound treatment.</p> <p>The October TAR lacked any information related to the treatment ordered on 10/2/13 having been done from 10/3/13 through 10/6/13.</p> <p>A nursing note entry, dated 10/6/13 at 12:48 a.m., indicated "Received new order from MD. Hold Polymem treatment times 7 days or until comes in. Start wet to dry. Cleanse wound bed with normal saline soak gauze pack into wound bed cover with abdominal [pad] and secure with cover all...."</p> <p>The clinical record indicated the resident was admitted to the hospital from 10/7/13 through 10/29/13 for treatment of a urinary tract infection and hypotension.</p> <p>RN#10 and LPN#11 were interviewed on 11/20/13 at 1 p.m. LPN #11 indicated she did not know why the nurse who took the new 10/2/13 order had not written the order so it would appear on the treatment sheet. RN#10 indicated she had no information to provide related to any treatment having been completed from 10/3/13 through 10/6/13.</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 11/20/2013	
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>2.) During an observation on 11/19/13 at 9:25 a.m., the resident was resting in bed. The bunny boots were not on the resident while in bed per order.</p> <p>During an observation on 11/20/13 at 10:00 a.m., the resident was resting in bed. The bunny boots were not on the resident while in bed per order.</p> <p>The clinical record for Resident #G was reviewed on 11/18/13 at 12:30 p.m.</p> <p>Diagnoses for Resident #G included, but were not limited to, hypertension, urinary tract infection, post operative pain, esophageal reflux, history of hip fracture, paranoid state, depressive disorder, psychosis.</p> <p>A health care plan problem, initiated on 8/23/13 and revised on 9/28/13, "Altered skin integrity non pressure related to: capillary fragility" indicated Resident #G was at risk for skin impairment. Interventions included but were not limited to, "bunny boots to bilat (bilateral) feet, place pillow under legs to off load pressure to heels when in bed", initiated 6/10/13.</p> <p>Resident #G had a physician's order for "bunny boots to bilateral feet, place pillow under legs to off load</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 11/20/2013	
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>pressure to heels when in bed". The original order date was 1/9/11.</p> <p>The Skilled Wing - Hall 2 Certified Nursing Assignment Sheets, provided by the Administrator on 11/20/13 at 12:40 p.m., indicated "bunny boots in bed, use pillows under legs to off load pressure..." under the devices and special needs section for Resident #G.</p> <p>During an interview on 11/19/13 at 9:30 a.m., LPN #1 indicated she was unaware the bunny boots were not on the resident and indicated she was aware of the order for the bunny boots to be worn while the resident was in bed.</p> <p>During an interview on 11/20/13 at 10:00 a.m., LPN #1 indicated she was unaware the bunny boots were not on the resident and indicated she was aware of the order for the bunny boots to be worn while the resident was in bed.</p> <p>3. The revised 2/25/10, "Clinical Guideline: Skin Integrity" Policy was provided by the Administrator on 11/20/13 at 2:35 p.m. The Skin Care Guidelines indicated:</p> <p>"Purpose: To provide a systemic approach and monitoring process for</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 11/20/2013
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>skin. To decrease pressure ulcer formation by identifying those residents who are at risk and developing interventions.</p> <p>Objective: Decrease the prevalence and incidence of residents that develop pressure ulcers. Provide guideline for optimal care to promote healing to residents with all identified alterations in skin integrity...</p> <p>...General Policy: ...DNS (Director of Nursing Services) or designee will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis...</p> <p>...Documentation and Care Interventions for Skin Integrity: ...If identified risk present the interventions will be documented in the Immediate Plan of Care or Comprehensive Care Plan...."</p> <p>3.1-40(a)(2)</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 11/20/2013
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	
F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 2 of 3 residents (Resident #C and #G) reviewed for care and services related to their need for an indwelling Foley catheter had complete orders for and/or received catheter care services to prevent a strong urine odor and possible catheter related complications.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #C was reviewed on 11/18/13 at 1:45 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, congestive heart failure, coronary atherosclerosis, chronic kidney disease, acute and chronic respiratory failure with tracheostomy,</p>	F000315	F-315 It is the policy of this facility to provide adequate catheter care to minimize odors and other possible catheter related complications. Resident # C and #G order was corrected on 11/29/2013 to provide the appropriate size of catheter and bulb size, catheter care orders and maintaining catheter care. Resident # G had foley catheter changed per physician orders on 11/19/13 at 11 am due to leakage. Because all residents that have foley catheters are potentially affected by the cited deficiency, on 12/29/2013 , the Director of Nursing will review all residents that have foley catheters to ensure that all orders include foley catheter and bulb size, catheter care orders, and orders for maintaining foley catheter. No other residents were affected. To enhance currently compliant operations and under the direction of the Director of Nursing, on 12/13/2013, licensed	12/20/2013	

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 11/20/2013	
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>toxic encephalopathy, and malignant carcinoid tumor of the descending colon .</p> <p>A nursing note entry, dated 11/1/13 at 4:30 p.m., indicated Resident #C was admitted to the facility with a rectal tube, foley catheter, gastrostomy tube, and gallbladder drain in place. The note indicated "resident sometimes opens eyes to physical stimuli; otherwise is unresponsive..." The note lacked any information related to the size of the catheter and bulb in place at the time of the admission.</p> <p>A physician's order, dated 11/1/13, indicated "Maintain foley catheter each shift. Drain and record amount in catheter bag each shift." The clinical record lacked any information related to the size of the catheter and bulb to be maintained, how often catheter care was to be provided, and/or when the catheter was to be changed or reanchored.</p> <p>RN #7 (Unit Manager for Resident #C's unit) was interviewed on 11/19/13 at 9:50 a.m. Additional information was requested related to the lack of catheter care orders and services provided. RN #7 reviewed the resident's computerized chart and</p>		<p>nurses will receive in-service training regarding state and federal requirements for obtaining appropriate orders for foley catheters to include size of catheter and bulb, catheter care orders, and orders for maintaining foley catheters. Nursing staff will receive in-service training regarding proper catheter care. Nursing staff will be checked off on catheter care on 12/13/2013 . Inservice training to be completed by Director of Clinical education. Effective 12/19/2013, a quality assurance program will be implemented under the supervision of the Director of Nursing to monitor residents with catheters to ensure appropriate physician order and to ensure that catheter care is provided as directed. Orders and catheter care are to be monitored five times a week for two weeks then weekly for four weeks. Any deficiencies or deficient practice will be corrected, and findings of the quality assurance committee meeting for further review or corrective images.</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 11/20/2013
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>hard chart and indicated the facility only had the admission order related to maintaining the catheter and measuring the urine every shift as noted above. She indicated the facility had not called the physician to clarify or obtain any other catheter care orders for the resident.</p> <p>RN #4 (also identified as the Nurse Clinical Educator) was interviewed on 11/19/13 at 9:50 a.m. When queried regarding basic orders needed for catheter care and maintenance, she indicated she would expect the size of the catheter and bulb to be in the order. She indicated orders should be obtained for how often catheter care is to be provided and when the catheter is to be changed or reanchored.</p> <p>2.) During an observation on 11/18/13 at 1:15 p.m., CNA #5 and CNA #6 were transferring Resident #G from wheelchair to the bed by a mechanical lift. There was a strong urine odor in the room. CNA #5 indicated Resident #G had a Foley catheter and thought the urine odor came from urine leaking from the catheter due to positioning. The resident was placed in bed and the incontinence brief was removed. The inside of the brief appeared damp and slightly discolored. CNA #5 and CNA #6 wiped the outer</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 11/20/2013	
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>perineal area of the resident with a damp cloth then patted the area dry. A clean brief was positioned under the Resident. At no time during the observation did the CNAs open the labia and clean the catheter tubing. The urine in the catheter collection bag was dark yellow/brown with some sediment observed.</p> <p>During an observation on 11/19/13 at 11:00 a.m., LPN #1 performed a Foley catheter change on Resident #G. The current order dated 9/20/13, indicated "#18 Foley catheter with 30 cc bulb to gravity drainage, change as needed for accidental removal or not draining as needed." A dried discolored substance was noted on the tubing and at the tip of the catheter. Thick greenish yellow urine was noted in the catheter tubing. LPN #1 stated, "the tip had a lot of calcification." LPN #1 also indicated she had last changed the Foley catheter approximately three weeks ago. There was a strong urine smell in the room.</p> <p>The clinical record for Resident #G was reviewed on 11/18/13 at 12:30 p.m.</p> <p>Diagnoses for Resident #G included, but were not limited to, hypertension, urinary tract infection, post operative pain, esophageal reflux, history of hip fracture, paranoid state, depressive disorder, and</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 11/20/2013
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>psychosis.</p> <p>The medical record review indicated an order for a #18 Foley catheter with 30 cc bulb to gravity drainage, change as needed for accidental removal or not draining as needed was initiated on 9/20/13. There was also an order for the U/D bag (urinary drainage) to be changed every 2 weeks initiated on 7/17/13. The urinary bag was to be emptied after every shift and amounts recorded. No other catheter care orders were present.</p> <p>In the Nurses notes dated 10/10/13 at 10:29 p.m., documentation indicated the Foley catheter had been changed. The Treatment Record indicated the urine bag had been changed 11/6/13 and was due to be changed again on 11/20/13.</p> <p>The resident had a care plan problem "Alteration in elimination of bowel and bladder indwelling Urinary Catheter/due to wound". Problem originated 7/24/13 and was last revised 9/28/13.</p> <p>Interventions included, but were not limited to, avoid excessive tugging on the catheter during transfer and delivery of care, change catheter bag every two weeks and as needed, change Foley catheter as needed, check catheter tubing for proper drainage and positioning.</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 11/20/2013
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>In an interview with LPN #1 on 11/18/13 at 1:15 p.m., LPN #1 indicated the order for the Foley catheter was changed as needed only and would have been documented in the nurses notes.</p> <p>In an interview on 11/19/13 at 1:48 p.m., RN #7 stated "I couldn't find any orders for cath (catheter) care prior to the one hospice wrote today." She indicated she had looked back through past orders and could not find any catheter care orders.</p> <p>3. The 2006, "Catheter Care, Indwelling Catheter" was provided by the Nurse Clinical Educator on 11/19/13 at 10:40 a.m. The policy indicated:</p> <p>"...Purpose: To prevent infection. To reduce irritation.</p> <p>...Procedure: Wash perineum well with soap and warm water, taking care to wash from front to back...Cleanse area well at catheter insertion, taking care not to pull on catheter or advance further into the uretha. All debris must be removed from the catheter at insertion site. Rinse well with warm water and pat dry gently with clean towel...</p> <p>...Documentation Guidelines: Documentation may include: Date,</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 11/20/2013	
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>time, procedure, condition of the perineum and catheter insertion site. Any unusual condition or change in the condition. Color, amount, consistency and odor of urine. Notification of the physician of any condition change. Intake and output and evaluation of intake and output per facility procedure. Signature and title...."</p> <p>4. The undated policy for "Perineal Care" was provided by the Administrator on 11/20/13 at 1:06 p.m. The policy indicated:</p> <p>"...Purpose: The purpose of perineal care is to: Cleanse the perineum. Prevent infection and odor...."</p> <p>5. The 2006, "Perineal Care" Procedure was provided by the Administrator on 11/20/13 at 2:45 p.m. The procedure indicated:</p> <p>"...Female perineal care:</p> <p>...e. Ask resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees, the perineal area can be washed with the resident on the side with legs flexed...</p> <p>...h. Dry the area well, remove bedpan, and position resident on</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 11/20/2013
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	
	back...." 3.1-41(a)(2)				

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 11/20/2013	
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			
F000328 SS=G	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on clinical record review and interview, the facility failed to ensure 2 of 3 residents (Resident #C and #E) reviewed for tracheostomy care and services had complete orders for tracheostomy care resulting in a build up of secretions requiring the need for hospital evaluation and treatment for one of the residents.(Resident #C).</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #C was reviewed on 11/18/13 at 1:45 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, congestive heart failure, coronary atherosclerosis, chronic kidney disease, acute and chronic respiratory failure with tracheostomy, toxic encephalopathy, and malignant carcinoid tumor of the descending</p>	F000328	F-328 It is the policy of this facility to provide adequate tracheotomy care and services. Resident #C and #E orders were reviewed by the Director of Nursing services to ensure that orders are complete to include, suctioning, dressing changes, inner cannula maintenance. All orders were corrected on 11/29/2013 under the direction of the Director of Nursing. Because all residents that have tracheotomy care are potentially affected by the cited deficiency, on 11/29/2013, the Director of Nursing services to ensure that orders were complete to include, suctioning, dressing changes, inner cannula and maintenance. No other issues were observed. To enhance currently compliant operations and under the direction of the Director of Nurses, on 12/13/2013 licensed staff will receive in-service training appropriate tracheotomy care in-services by the Director of Clinical Education. The training emphasized the	12/20/2013			

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 11/20/2013
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>colon . The clinical record indicated the resident was unable to take food orally and had a gastrostomy tube for nutritional feedings.</p> <p>A nursing note entry, dated 11/1/13 at 4:30 p.m., indicated Resident #C was admitted to the facility with a rectal tube, foley catheter, gastrostomy tube, and gallbladder drain in place. The note indicated "resident sometimes opens eyes to physical stimuli; otherwise is unresponsive..."</p> <p>Admission orders, dated 11/1/13, indicated "Oxygen at 21% via trach collar with humidifier. Trach is a #9 Porter Trach." The orders also indicated the resident was to have an Albuterol (a inhalation medication given to help improve respirations) nebulizer treatment every 8 hours related to acute and chronic respiratory failure.</p> <p>The admission orders lacked any information related to how often the resident's tracheostomy dressing was to be changed, how often the resident's inner cannula was to be cleansed and/or changed, or any information about the possible need to suction the inner cannula to prevent secretion build up and decreased patency of the airway.</p>		<p>importance of obtaining appropriate tracheotomy orders to include, suctioning, dressing changes, inner cannula maintenance. Licensed nurses were in-serviced on how to provide appropriate tracheotomy care with return demonstration. Effective 12/19/2013, a quality assurance program will be implemented under the direction of the Director of Nursing to monitor residents that are receiving tracheotomy care. The Director of Nursing or designated quality assurance representative will perform audits on all residents that currently have tracheotomy care orders. Audits will be completed on all new admissions with tracheotomy care orders for four weeks and then monthly for three months with any deficiencies found will be corrected. The findings of the quality assurance checks will be documented and submitted on at the monthly quality assurance committee meeting for further review or corrective action.</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 11/20/2013	
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>A nursing note entry, dated 11/3/13 at 10:59 p.m., indicated "...Trach midline and patent. Trach care provided with deep tracheal suctioning, site care per sterile technique...."</p> <p>A nursing note entry, dated 11/4/13 at 1:22 a.m., indicated "...trach midline with no redness or drainage. secretions noted clear and yellow...."</p> <p>A nursing note entry, dated 11/4/13 at 3:32 p.m., indicated "Trach care provided... Inner cannula suctioned for increased secretions... Drsg [dressing changed]...."</p> <p>A nursing note entry, dated 11/6/13 at 10:22 a.m., indicated "...trach care done..." The noted did not indicate was included in the trach care provided.</p> <p>These were the only documentation of trach care services noted from 11/1/13 through 11/6/13.</p> <p>A nursing note entry, dated 11/7/13 at 11:19 a.m., indicated "Received clarification for trach cannula orders.... Change #9 inner trach cannula once a day..." The clinical record lacked any information related to the inner cannula being changed</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 11/20/2013
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>until 11/8/13.</p> <p>A nursing note entry, dated 11/9/13 at 11:02 a.m., indicated "frequent trach care done this shift, moderate sputum yellowish/greenish noted, inner cannula changed as ordered...."</p> <p>A nursing note entry, dated 11/10/13 at 3:32 a.m., indicated "res with thick yellow/tan secretions suctioned with large amounts of secretions obtained res diaphoretic... trach care completed with inner cannula changed."</p> <p>A nursing note entry, dated 11/10/13 at 4:24 a.m., indicated "MD notified of change in resident received new order to send to [initials of hospital] to be evaluated and treated...."</p> <p>The clinical record indicated the resident returned to the facility on the same date and had pleural effusions. The record indicated the physician was not going to put the resident on an antibiotic at that time.</p> <p>A new order was obtained following the resident's readmission, dated 11/10/13 at 8:07 a.m., that indicated "Assess for secretions every four hours for possible suctioning and humidified oxygen every 4 hours as</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 11/20/2013
--	---	--	---

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>needed for trach related to acute and chronic respiratory failure."</p> <p>RN #7 (Unit Manager for Resident #C's unit) was interviewed on 11/19/13 at 9:30 a.m. Additional information was requested related to the lack of trach care orders and services provided. RN #7 reviewed the resident's computerized chart and hard chart and indicated the facility only had admission orders for the size of the trach and the oxygen content at time of admission. She was unable to find any additional trach care orders other than the ones obtained on 11/7/13 and 11/10/13 noted above.</p> <p>RN #4 (also identified as the Nurse Clinical Educator) was interviewed on 11/19/13 at 9:40 a.m. When queried regarding basic orders needed for tracheostomy care, she indicated she would expect orders for site care, suctioning as needed, cannula size, cannula cleaning and/or changing information in addition to any oxygen orders.</p> <p>2. The clinical record for Resident #E was reviewed on 11/18/13 at 12:19 p.m.</p> <p>Diagnoses for Resident #E included, but were not limited to, dysphagia, hemiplegia affecting non-dominant</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 11/20/2013
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>side, hypertension, and diabetes.</p> <p>The clinical record lacked an order for suctioning of the tracheostomy.</p> <p>During an interview with Medical Records #2 on 11/20/13 at 8:10 a.m., additional information was requested related to suctioning orders for Resident #E.</p> <p>During an interview with the acting Director of Nursing and LPN #3 on 11/20/13 at 2:10 p.m., they indicated Resident #E had no order for tracheostomy suctioning.</p> <p>3. The undated policy for "Tracheostomy Care" was provided by Nurse Clinical Educator on 11/19/13 at 12:10 p.m. The policy indicated:</p> <p>"...Purpose: To provide adequate tracheostomy site care: Maintain a patent airway, to facilitate the therapeutic exchange of gases. Prevent the transmission of pathogenic microorganisms thus decreasing nosocomial infections.</p> <p>Policy: Stoma care for tracheostomy should be done every shift and PRN (as needed) unless otherwise ordered.</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 11/20/2013	
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>Assessment: General guidelines for assessment may include, but not limited to: ...Observe characteristics of secretions increase/decrease, thick/thin, color, blood tinged...Observe for signs or symptoms of respiratory distress...."</p> <p>4. The undated policy for "Tracheostomy Suctioning" was provided by Nurse Clinical Educator on 11/19/13 at 12:10 p.m. The policy indicated:</p> <p>"Responsible: The following individuals may have responsibility for tracheostomy suctioning, consistent with state specific professional licensing requirements. Only licensed nurse per MD (Doctor of Medicine) orders.</p> <p>Purpose: To provide adequate tracheostomy suctioning: Maintain a patent airway, to facilitate the therapeutic exchange of gases...</p> <p>Policy: Tracheostomy suctioning should be done PRN (as needed).</p> <p>Assessment: General guidelines for assessment may include, but are not limited to: ... Observe characteristics of secretions increase/decrease,</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 11/20/2013
--	---	--	---

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>thick/thin, color, blood tinged...Observe for signs or symptoms of respiratory distress....</p> <p>3.1-47(a)(5) 3.1-47(a)(4)</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 11/20/2013	
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			
F000412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on record review and interview, the facility failed to provide dental services in a timely manner for 1 of 1 resident reviewed who had lost multiple teeth. (Resident #53)</p> <p>Findings include:</p> <p>The clinical record for Resident # 53 was reviewed on 11/19/13 at 2:20 p.m.</p> <p>Diagnoses included, but were not limited to, psychosis, malignant neoplasm of prostate, dysphagia (4/17/09), and dementia.</p> <p>During an interview on 11/15/13 at 10:55 a.m., Resident #53's wife indicated he had several missing teeth and had problems chewing food. She indicated he now received a pureed diet.</p>	F000412	F-412 It is the policy of this facility to provide dental services in a timely manner in order to prevent increase in oral discomfort and decay. In this case, resident #53 was to be seen by the dentist on 8/29/13 and was not seen. Because all residents are at risk for oral difficulties, all current residents were provided a dental assessment. All residents that were noted to have dental issues were referred to the dentist. Residents that are needed to be seen by the dentist will have services coordinated by Social Services. To enhance currently compliant operations and under the direction of the Director of Nursing services, on 12/13/2013 licensed staff, Social Services and therapy will receive in-service training regarding obtaining dental services and ensuring that communication is completed by the Director of Clinical Education. Effective 12/19/2013, a quality assurance program will	12/20/2013			

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 11/20/2013
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>The clinical record indicated the resident was noted to be pocketing food on 7/25/13. He was observed for several days and the problem continued. The clinical record indicated the resident was also noted to have lost several teeth. The resident's wife and physician were contacted on 7/29/13 and orders were received for a speech therapy evaluation and the resident was to be seen by the dentist. The clinical record indicated the dentist was due to visit on 8/29/13 and the resident would be seen at that time.</p> <p>The clinical record lacked any information related to the resident being seen by the dentist on 8/29/13. The last dental visit in the clinical record was dated 8/15/12.</p> <p>LPN #13 was interviewed on 11/20/13 at 11 a.m. Additional information was requested related to the lack of dental visit information for 8/29/13. LPN #13 indicated she was unable to find any 8/29/13 dental visit information.</p> <p>RN #10 was interviewed on 11/20/13 at 3:15 p.m. She indicated she had consulted with the Social Services Director (SSD) and he indicated</p>		<p>be implemented under the supervision of the Director of Nursing and Social Services to ensure that residents receive dental care as needed. Social Services will assist with coordinating resident's appointments with the dentist. The Director of Nursing or designated quality assurance representative will check on weekly basis for three months to ensure that residents with dental appointments are kept with any deficiencies to be corrected, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committed meeting for further review or corrective action.</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 11/20/2013
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>Resident #53 had not been put on the 8/29/13 list for the dentist to see. RN#10 indicated she had discovered there was a problem with the resident seeing the dentist because the resident's wife owed the dentist a large sum of money for previous dental work for the resident. She indicated the SSD was not aware of the need for the resident to be seen or he would have tried to work out a solution. She indicated since the resident was now a Medicaid resident they were completing paperwork to set up a dental visit.</p> <p>3.1-24(a)(1)</p>				