

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MUNCIE		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 12, 13, 14, 15, 16, and 19, 2016</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Census bed type: SNF/NF: 92 SNF: 0 NF: 0 Total: 92</p> <p>Census payor type: Medicare: 7 Medicaid: 82 Other: 3 Total: 92</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 35984 on December 21, 2016.</p>	F 0000	This plan of correction constitutes the facility's written allegation of compliance; however, the plan is not an admission that a deficiency existed or that one was cited correctly. The plan of correction is being submitted to meet the requirements of state and federal law.	
F 0157 SS=D	483.10(g)(14) NOTIFY OF CHANGES			

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 <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
Bldg. 00	<p>(INJURY/DECLINE/ROOM, ETC)</p> <p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>Based on record review and interview, the facility failed to notify the physician of a weight gain in accordance with the physician's order for 1 of 26 residents reviewed for physician notification. (Resident #100)</p> <p>Findings include:</p> <p>The clinical record for Resident #100 was reviewed on 12/14/16 at 12:33 p.m. Diagnoses for the resident included, but were not limited to, dementia with Lewy bodies, psychosis, heart failure, and diabetes.</p> <p>The resident had a current physician order weekly weights due every Sunday. The order indicated to call the physician for a weight gain or weight loss of five pounds weekly. This order originated 6/16/16.</p> <p>Review of the September 2016, Medication Administration Record, indicated the resident's weight increased 5.3 pounds from 9/4/16 to 9/11/16, and</p>	F 0157	<p>MD notified on 12.20.16 of Res #100 weight gain.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>All residents were reviewed to identify anyone with a weight change. Anyone identified with a weight change in accordance with physician's order was reviewed to ensure MD and family was notified of such.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</p> <p>Licensed staff in-serviced on notifying MD and family immediately when a change of condition (such as a weight loss/gain in accordance with physician's order) has been identified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	01/13/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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>increased 6.1 pounds from 9/18/16 to 9/25/16.</p> <p>The clinical record lacked any documentation of the physician having been notified of the resident's weight gain.</p> <p>During an interview on 12/19/16 at 7:56 a.m., LPN #7 indicated a nurse progress note would need to be completed to document the notification of the physician regarding any change in condition for a resident.</p> <p>During an interview on 12/19/16 at 1:05 p.m., the Director of Nursing indicated she (the facility) did not have any documentation of Resident #100's physician having been notified of his weight gain per the physician's order.</p> <p>The current, 10/20/16, facility policy, titled "Notification of Change in Resident Health Status," provided by the Director of Nursing, on 12/19/16 at 2:05 p.m., included, but was not limited to, the following:</p> <p>"GUIDELINE STATEMENT: To ensure that proper notifications are made when a resident has a change in health status...</p> <p>...(B) Acute illness or a significant</p>		<p>practice does not recur.</p> <p>DNS/designee to review nurses notes 5 times weekly to ensure physician and family notified of any change of condition. DNS/designee to also review weekly/monthly weights to ensure MD/family notified of any weight changes in accordance with physician's order that have occurred. Change of condition audits to be completed 5 times weekly during clinical start up. Weight audits to be conducted 5 times weekly x 30 days, 3 times weekly x 30 days, 2 times weekly x 30 days then weekly times 90 days.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0329 SS=E Bldg. 00	<p>change in the resident's physical, mental, or psychosocial status (i.e. deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications)...</p> <p>...(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> <p>483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who received psychopharmacological medication had identified behavioral symptoms and/or targeted behaviors being treated by the use of these medications and/or had a method to monitor these resident specific behavioral symptoms for 4 of 5 residents reviewed for unnecessary medication (Residents #105, #64, #100 and #95) and the facility failed to monitor blood sugars as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident #100).</p> <p>Findings include:</p> <p>1. Resident #105 was observed seated calmly in her room or in a common area during the following dates and times 12/15/16 at 9:32 a.m., 12/15/16 at 3:11 p.m., 12/16/16, 9:04 a.m., and 12/19/16 at 8:18 a.m.</p> <p>Resident #105's clinical record was reviewed on 12/15/16 at 10:01 a.m. Her current diagnoses included, but were limited to, Alzheimer's disease, anxiety, depression and psychosis.</p>	F 0329	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The behavior tracking flow sheets for Res #105 have been reviewed and updated to reflect resident specific targeted behavioral symptoms. Behavior tracking flow sheets for Res #105 have been updated to reflect resident specific targeted behavioral symptoms.</p> <p>Psychoactive medications for Res#64 reviewed with recommendations made for trial GDR. Will continue to monitor Res #64 for further behaviors. Behavior tracking flow sheets for Res #64 also reviewed and updated to reflect resident specific targeted behavioral symptoms.</p> <p>Psychoactive medications were reviewed for Res#95 and Res #100 for indication of use. The behavior tracking flow sheets were also reviewed and updated to reflect resident specific targeted behavioral symptoms. A specific targeted behavior was also identified for each drug that it was being monitored for.</p> <p>MD/family notified Res #100 did not have Blood Sugar rechecked as per order for BS >400 on dates identified per surveyor.</p>	01/13/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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 had current physician's orders for the following psychoactive medications:</p> <p>a. Zyprexa 2.5 mg (an anti-psychotic medication) one tablet one time daily related to unspecified psychosis. This order originated 8/5/16.</p> <p>b. Hydroxyzine HCL tablet (an anti-anxiety medication) give 10 mg by mouth three times daily related to anxiety. This order originated 4/24/16.</p> <p>c. Clonazepam 0.5 mg (an anti-anxiety medication) one tablet every 12 hours as needed for anxiety. This order originated 4/19/16.</p> <p>The resident had a current, 10/17/16, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired, rarely or never made independent decisions and displayed no maladaptive behaviors during the assessment period.</p> <p>The resident's "Behavior Monthly Flow Sheet" for November 2016 and December 2016 (12/1/16 to 12/15/16) were reviewed. The tracking flow sheet did not contain any resident specific targeted behavioral symptoms. The flow sheet indicated "Anxiety" and</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</p> <p>All residents who receive psychopharmacological medication were reviewed to ensure behavioral symptoms had been identified and/or targeted behaviors were being treated by use of the medications. Anyone identified to have been affected by the deficient practice had their behavior tracking log updated to reflect resident specific targeted behavioral symptoms or if no targeted behaviors could be identified than a trial GDR of the psychoactive medication to be completed.</p> <p>All residents who have orders for blood sugars were reviewed to ensure they are being monitored per physician order. MD/family notified of blood sugars not being monitored per physician's order for any resident found to have been affected by the deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Licensed nursing staff and SS staff in-serviced that all residents who receive psychopharmacological medication must have behavioral symptoms present and/or targeted behaviors that the medication is</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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>"Hallucinations/paranoia/delusions." The record did not explain how the resident displayed these diagnoses.</p> <p>The resident's nursing progress notes for October 2016 through December 15, 2016 contained two "Behavior/Mood" events as follows:</p> <p>On 12/5/16, 1:18 p.m., note indicated during lunch the resident was crying and stated she was no good and the non-chemical intervention of telling her she was loved stopped her crying.</p> <p>On 12/9/16, 1:32 p.m. note indicated the resident was tearful at lunch and the non-chemical intervention of offering her a different type of food was effective and the resident stopped crying.</p> <p>The "Behavior Meeting Notes" for August through November 2016 were reviewed. Resident #105 name was not listed as reviewed in any of the four months of notes.</p> <p>On 12/16/16 at 8:20 a.m., the DON provided nursing progress notes from shortly after Resident #105's admission. The DON indicated these behaviors were the behavioral symptoms for the use of the resident's psychopharmacological medications. The nursing progress notes</p>		<p>treating for the resident to continue or be started on a psychoactive medication. Licensed staff also in-serviced on following a physician's order including monitoring blood sugars per guidelines set by physician.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.</p> <p>DNS/SSD/designee to review in clinical start up any behaviors from previous day for any follow up needed. DNS/SSD/designee to review behavior tracking logs prior to them being placed on units each month to ensure resident specific targeted behaviors are listed on log.</p> <p>DNS/SSD/designee to also ensure that behavioral symptoms present prior to any resident starting a new psychoactive medication. These behavior audits to be completed 5 times weekly x 30 days, 3 times weekly times x 30 days, 2 times weekly x 30 days, then weekly x 90 days.</p> <p>UM/designee to review Blood Sugars from previous day to ensure they are being monitored per physician's order including be rechecked if ordered. These blood sugar audits to be completed 5 times weekly x 30 days, 3 times weekly x 30 days, 2 times weekly x 30 days, then weekly x 90 days.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
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 as followed:</p> <p>On 4/19/16 at 7:00 p.m., "Appeared res could not focus on meal d/t [due to] anxious.."</p> <p>On 4/19/16 at 7:30 p.m., "Res [resident] extremely restless, wandering, anxious since admit."</p> <p>On 4/23/16 at 6:32 a.m., "Res agitated going into others room packing items from the closet."</p> <p>On 4/23/16 at 11:00 p.m., "Resident running up and down halls on step up [unit] yelling and screaming and combative towards staff and banging on back door..."</p> <p>Although these behavioral symptoms were identified by the facility as the symptoms being treated by the psychopharmacological medications, the residents record lacked any behavioral symptom tracking regarding, anxious wandering, running up and down hallways, yelling, pounding doors or rummage in other resident's closets.</p> <p>During a 12/16/16, 10:45 a.m., interview the Director of Nursing (DON) was questioned regarding Resident #105's behavioral symptoms for the use of her</p>			<p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>psychopharmacological medications. The DON indicated she would review the matter and provided information on 12/19/16.</p> <p>During a 12/19/16, 8:28 a.m., interview the DON indicated Resident #105's behavioral flow sheet did not monitor the residents targeted behavioral symptoms for the use of her psychopharmacological medications. She indicated the tracking records were general and not specific to the resident.</p> <p>2. Resident #64 was seated calmly in her room or in a common area during the following dates and times: 12/15/16 at 9:34 a.m., 12/15/16 at 3:12 p.m., 12/16/16 at 9:05 a.m., and 12/19/16 at 8:19 a.m.</p> <p>Resident #64's clinical record was reviewed on 12/15/16 at 3:18 p.m. The resident's current diagnoses included, but were not limited to, dementia with behavioral disturbances, delusional disorder, depression and anxiety.</p> <p>The resident had current physician's orders for the following psychopharmacological medications:</p> <p>a. Ativan 0.5 mg (an anti-anxiety medication) 0.25 mg one time daily for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>anxiety. This order originated 9/21/16.</p> <p>b. Depakote Sprinkles 125 mg (an anti-seizure medication also used as a mood stabilizer) one tablet once daily for dementia with behavioral disturbances. This order originated 11/18/16.</p> <p>c. Fluoxetine HCL 20 mg (an antidepressant medication) one tablet daily for depression. This order originated 6/1/16.</p> <p>d. Zyprexa 2.5 mg (an anti-psychotic medication) one tablet daily at bedtime for delusional disorder. This order originated 11/23/16.</p> <p>The resident had a current, 10/14/16, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired, rarely or never made independent decisions and displayed no maladaptive behaviors during the assessment period.</p> <p>The resident's "Behavior Monthly Flow Sheet" for November 2016 and December 2016 (12/1/16 to 12/15/16) were reviewed. The tracking flow sheet did not contain any resident specific targeted behavioral symptoms. The flow sheet indicated "Agitated, Angry, Anxiety...Depressed withdrawn... Rejects</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
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>care." The monitoring flow sheet did not indicate the resident's specific agitated behavior, angry behavior, anxious behavior or withdrawn behavior." The form stated generalized concerns. In addition, the monitoring form combined depression withdrawn with rejection of care and monitored them in one area. The form also combined agitated with angry and monitored it in one area.</p> <p>The "Behavior Meeting Notes" for August through November 2016 were reviewed. Resident #105 name was listed as reviewed once in the four months of notes. A 9/29/16 note indicated the resident had a reduction in Ativan and psych services was to follow up with the resident.</p> <p>On 12/16/16 at 8:20 a.m., the DON provided nursing progress notes prior to Resident #64 being started on Zyprexa and Depakote. The DON indicated the behaviors documented in the notes were the behavioral symptoms for the use of the resident's psychopharmacological medications. She indicated the Alzheimer's unit staff had identified which behavioral symptom was being treated by the use of the resident's psychopharmacological medications. The nursing progress notes and staff identified symptoms and treatments were</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>as follows:</p> <p>On 11/12/16 at 1:50 a.m., the resident was sitting in her rocker and had been up since 11:30 p.m. Resident did not believe room was her home. The resident wanted to sit in the rocker and be left alone. The resident rocked in her chair and eventually went back to bed.</p> <p>On 11/17/16 at 1:57 p.m., the resident repeatedly went to the door wanting to go home. The resident was redirected and would later return and want to go home. The record indicated the resident was not putting herself or others at risk. The record indicated she displayed the behavior on multiple times and was easily redirected each time. The facility identified this re-directed behavior as a medical justification to begin the anti-psychotic medication Zyprexa.</p> <p>On 11/18/16 at 3:22 a.m., the resident was up three times during the night seeking her husband and parents. She yelled at staff. The resident was reminded of the time of day and she went back to bedroom after each event. Although the resident was successfully redirected back to bed after each episode, the facility identified this behavioral episode as a reason to begin the anti-psychotic medication Zyprexa.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
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>On 11/19/16 at 10:10 a.m., the resident refused to get dressed at this time. She ate breakfast and returned to bed to sleep. The facility identified this residents desire to sleep late and wear night clothing, as a behavioral indicator for the use of the mood stabilizer Depakote.</p> <p>On 11/19/16 at 2:01 p.m., the resident was upset that her roommate was in the room. She believed she owned the whole room. The resident was calmed and redirected with conversation.</p> <p>On 11/24/16 at 7:15 p.m., The resident was agitated and yelling at another resident in the dining room because someone kicked another person (unsure if accidental or intentional). The resident yelled "shut up." The resident was redirected and calm after being served her food. Although the resident calmed when served her meal, the facility identified this behavioral symptoms as indication for the use of the anti-psychotic medication Zyprexa being initiated.</p> <p>On 11/27/16 at 2:32 p.m., at approximately 12:30 a.m. the resident was up with clothes piled on her walker heading down the hall. She was agitated about finding her husband and eight year</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
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>old daughter. The resident was left alone to rock in the rocker in her room. She calmed down and rocked but did not desire to go back to bed. The facility identified this behavior which calmed by rocking in her rocking chair, as a behavioral symptom for the use of the anti-psychotic medication Zyprexa.</p> <p>On 11/29/16 at 11:25 a.m., the resident told her roommate to get out of the room because the store was closed. The resident was calm with redirection.</p> <p>On 12/5/16 at 12:24 p.m., the resident refused shower three times. The facility identified this resident exercising her right to refuse care without a risk to health and/or safety as a behavioral indicator for the mood stabilizer Depakote.</p> <p>On 12/5/16 at 10:52 p.m., the resident became upset after dinner stating that people were in the store after it closed. The resident was upset and told her roommate to leave the store. The resident was given time to calm down and she went to bed and went to sleep, without any chemical intervention. The facility identified this behavior where the resident calmed down and went to sleep after a cooling down period as a behavioral symptom for the use of the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>anti-psychotic medication Zyprexa.</p> <p>On 12/6/16 at 8:47 p.m., the resident was exit seeking, anxious and "gotta get home" repeatedly. The interventions of redirection, distraction, snack/fluids and activity/singing were somewhat effective with time. The record did not indicate that this behavior put the resident or others at risk or negatively impacted the residents quality of life. The facility identified this event as a behavioral symptom which required the use of the anti-psychotic medication Zyprexa.</p> <p>On 12/8/16 at 2:33 p.m., the resident was agitated and accused another resident of being rude. The resident calmed when redirected to another area. The facility identified this behavior, which was redirected without chemical intervention, as a behavioral symptom that required the use of the mood stabilized Depakote.</p> <p>On 12/10/16 at 10:55 a.m., the resident refused to be cleaned up when approached, but agreed to be cleaned up at a later time.</p> <p>On 12/11/16 at 8:57 p.m., the resident refused to get ready for bed when first approach but agreed later, without any chemical intervention. The facility identified the residents refusal to get</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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>ready for bed prior to 9:00 p.m. as a behavioral indicator for the use of the mood stabilizer Depakote.</p> <p>On 12/12/16 at 11:21 p.m., the resident refused her shower twice.</p> <p>On 12/13/16 at 8:50 p.m., the resident was snappy, loud and rude with tablemate's during dinner. Once served her meal she focused on her meal and stopped her behavior, without any chemical intervention. The facility identified the resident being snappy, loud and rude as a behavioral indicator for the use of the mood stabilizer Depakote.</p> <p>On 12/15/16 at 9:23 p.m., the resident refused her shower two times. The facility identified this residents exercising her right to refuse showers was a behavioral indicator for the use of the mood stabilizer Depakote.</p> <p>During a 12/16/16, 10:45 a.m., interview, the Director of Nursing (DON) was questioned regarding Resident #64's behavioral symptoms for the use of her psychopharmacological medications. The DON was also questioned about the resident behavioral symptoms resulting in the resident being started on Zyprexa 11/23/16 and Depakote 11/18/16. The DON indicated she would review the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>matter and provided information on 12/19/16.</p> <p>During a 12/19/16, 8:28 a.m., interview the DON indicated Resident #64's behavioral flow sheet did not monitor the residents targeted behavioral symptoms for the use of her psychopharmacological medications. She indicated the tracking records were general and not specific to the resident.</p> <p>During a 12/19/2016, 10:59 a.m., interview the DON indicated the behavioral indicators for the use and initiation of Resident #64 psychopharmacological medications did not meet the standards for beginning or current use of the medications and the staff would need to be re-educated.</p> <p>3. On 12/13/16 at 7:24 a.m., Resident #95 was observed sitting in his recliner in his room. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/14/16 at 7:28 a.m., Resident #95 was observed sitting in the dining room. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/15/16 at 8:54 a.m., Resident #95 was observed sitting in his recliner in his room. He was calm and displayed no maladaptive behaviors.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
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>On 12/15/16 at 12:25 p.m., Resident #95 was observed ambulating with a cane in the hallway. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/15/16 at 3:09 p.m., Resident #95 was observed sitting in his recliner in his room. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/16/16 at 7:45 a.m., Resident #95 was observed sitting in the dining room, feeding himself without problems. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/16/16 at 11:02 a.m., Resident #95 was observed ambulating with a cane in the hallway. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/19/16 at 8:03 a.m., Resident #95 was observed sitting in the dining room, drinking a hot beverage. He was calm and displayed no maladaptive behaviors.</p> <p>The clinical record for Resident #95 was reviewed on 12/14/16 at 2:40 p.m. Diagnoses for the resident included, but were not limited to, dementia with behavioral disturbance, psychosis, and depression.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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 quarterly Minimum Data Set (MDS), dated 9/9/16, indicated the resident never/rarely made decisions, and displayed no maladaptive behaviors during the assessment period.</p> <p>Current physician's order for the resident included, but were not limited to the following orders:</p> <ul style="list-style-type: none"> a. Lexapro (an anti-depressant medication) 5 mg, one tablet by mouth at bedtime. This order originated 9/21/16. b. Risperdal (an anti-psychotic medication) 0.25 mg, one tablet by mouth once a day. This order originated 9/30/16. c. Risperdal (an anti-psychotic medication) 0.5 mg, one tablet by mouth at bedtime. This order originated 9/30/16. d. Trazodone (an anti-depressant medication) 25 mg, one tablet by mouth at bedtime. This order originated 3/30/16. <p>The December 2016, "BEHAVIOR MONTHLY FLOWSHEET," indicated monitored target behaviors for the resident included "Agitated, Continuous screaming/yelling, Striking out/hitting."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>The drugs listed were Lexapro, risperidone (Risperdal), and trazodone. There was no indication of which behavior was monitored for which drug.</p> <p>The November 2016, "BEHAVIOR MONTHLY FLOWSHEET", indicated monitored target behaviors for the resident included "Agitated, Continuous screaming/yelling, Striking out/hitting." The drugs listed were Lexapro, risperidone (Risperdal), and trazodone. There was no indication which behavior was monitored for which drug.</p> <p>The resident's clinical record lacked identified specific targeted behaviors for the use of Lexapro, risperidone, and trazodone. The resident's clinical record lacked a method to monitor for resident specific targeted behaviors for the use of Lexapro, risperidone, and trazodone.</p> <p>During an interview on 12/19/16 at 7:56 a.m., LPN #7 indicated staff will pass along in report which behaviors to watch for and/or document for each resident. She indicated staff document "out of the normal" behavior and staff can review nurses notes to know which behaviors have been documented. LPN #7 further indicated a binder with behaviors was started last month.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
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>During an interview on 12/19/16 at 8:28 a.m., the Director of Nursing (DON) indicated the behavior monitoring flow sheets did not have specific resident targeted behaviors. The flow sheets had words like "anxiety".</p> <p>During an interview on 12/19/16 at 1:05 p.m., the DON indicated the facility did not have resident specific targeted behaviors and were not monitoring for specific targeted behaviors for Resident #95.</p> <p>4 a. On 12/13/16 at 10:01 a.m., Resident #100 was observed in bed with his eyes open. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/14/15 at 7:38 a.m., Resident #100 was observed sitting in a common area and looking at the newspaper. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/15/16 at 8:20 a.m., Resident #100 was observed during an insulin medication observation in his room. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/15/16 at 10:25 a.m., Resident #100 was observed in his bed with the blanket over his head. The resident was snoring.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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>On 12/15/16 at 11:38 a.m., Resident #100 was observed ambulating in the hallway with his walker. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/15/16 at 3:10 p.m., Resident #100 was observed participating in a sing-a-long activity. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/16/16 at 7:31 a.m., Resident #100 was observed sitting in the dining room talking to other residents and staff. He was calm and displayed no maladaptive behaviors.</p> <p>On 12/16/16 at 12:00 p.m., Resident #100 was observed sitting in the dining room talking to other residents. He was calm and displayed no maladaptive behaviors.</p> <p>The clinical record for Resident #100 was reviewed on 12/14/16 at 12:33 p.m. Diagnoses for the resident included, but were not limited to, dementia with Lewy bodies, psychosis, depression, and diabetes.</p> <p>A quarterly Minimum Data Set (MDS), dated 9/12/16, indicated the resident never/rarely made decisions, and rejected care one to three days of the assessment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>period. No other maladaptive behaviors were displayed during the assessment period.</p> <p>Current physician's order for the resident included, but were not limited to the following orders:</p> <ul style="list-style-type: none"> a. Depakote sprinkles 125 mg, three capsules by mouth two times a day. This order originated 11/13/16. b. Duloxetine (an anti-depressant medication) 30 mg, one tablet by mouth once a day. This order originated 2/12/16. c. Risperdal (an anti-psychotic medication) 0.25 mg, one tablet by mouth at bedtime. This order originated 9/12/16 with a change of administration time on 11/1/16. <p>The November 2016, "BEHAVIOR MONTHLY FLOWSHEET", indicated monitored target behaviors for the resident included "Agitated, Hallucinations/paranoia/delusion, and Restless." The drugs listed were risperidone (Risperdal), duloxetine, and Depakote. There was no indication which behavior was monitored for which drug.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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 December 2016, "BEHAVIOR MONTHLY FLOWSHEET", indicated monitored target behaviors for the resident included "Agitated, Hallucinations/paranoia/delusion, Restless, Other: Rejecting Care." The drugs listed were risperidone (Risperdal), duloxetine, and Depakote. There was no indication which behavior was monitored for which drug.</p> <p>The resident's clinical record lacked identified specific targeted behaviors for the use of risperidone, duloxetine, and Depakote. The resident's clinical record lacked a method to monitor for resident specific targeted behaviors for the use of risperidone, duloxetine, and Depakote.</p> <p>During an interview on 12/19/16 at 7:56 a.m., LPN #7 indicated staff will pass along in report which behaviors to watch for and/or document for each resident. She indicated staff document "out of the normal" behavior and staff can review nurses notes to know which behaviors have been documented. LPN #7 further indicated a binder with behaviors was started last month.</p> <p>During an interview on 12/19/16 at 8:28 a.m., the Director of Nursing (DON) indicated the behavior monitoring flow sheets did not have specific resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>targeted behaviors. The flow sheets had words like "anxiety".</p> <p>During an interview on 12/19/16 at 1:05 p.m., the DON indicated they (the facility) did not have resident specific targeted behaviors and were not monitoring for specific targeted behaviors for Resident #100.</p> <p>Review of the current facility policy, undated, titled "Behavior Management Guideline", provided by Director of Nursing on 12/19/16 at 11:00 a.m., included, but was not limited to,</p> <p>"GUIDELINE STATEMENT: To develop behavior plans and medication regimens, when appropriate...</p> <p>Pre-admission: ...A patient's/resident's history of behaviors impacting functioning and any previous or current use of psychotropic medications are considered in the inquiry process...</p> <p>...Antipsychotic should not be used if the only indications is one or more of the following: ... insomnia ... nervousness ... uncooperativeness (e.g. refusal of or difficulty receiving care)...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
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>...Diagnoses alone do not warrant the use of an antipsychotic..</p> <p>...The behavioral symptoms present a danger to the patient/resident or others and one or both to the following:</p> <p>...the symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or behavioral interventions have been attempted and included in the plan of care, except in an emergency...</p> <p>...In addition, before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior/s must be clearly and specifically identified and documented."</p> <p>b. Resident #100 also had a current physician's order for Novolog FlexPen (an insulin), inject per sliding scale:</p> <p>0-50=0 Call MD [physician]; 51-60=0 give carbohydrate and recheck in 15 minutes, Call MD if less than 60; 61-250=0; 251-300=2 units; 301-350=4 units; 351-400=6 units; 401-450=8 units, recheck in two hours, if over 400 call MD;</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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)
	<p>451-500=10 units, subcutaneously before meals.</p> <p>The resident had a current, 2/12/16 dated, health care plan with the focus of "Alteration in Blood Glucose due to: Insulin Dependent Diabetes Mellitus." Interventions for this focus included, but were not limited to, "Labs per Physician order and PRN for change in condition/manifestation of clinical signs or symptoms", and "Observe for high blood sugar symptoms-increased thirst, increased hunger, increased urinary output".</p> <p>Review of the October, November, and December 2016, Medication Administration Records indicated a blood sugar result greater than 400 with no documented recheck of the blood sugar in two hours on the following dates and times:</p> <p>October 1, at 7:00 a.m., the blood sugar result was 487;</p> <p>October 5, at 7:00 a.m., the blood sugar result was 408;</p> <p>October 9, at 7:00 a.m., the blood sugar result was 412;</p> <p>October 9, at 11:30 a.m., the blood sugar</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016
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>result was 454;</p> <p>October 9, at 5:00 p.m., the blood sugar result was 478;</p> <p>October 14, at 11:30 a.m., the blood sugar result was 488;</p> <p>October 19, at 11:30 a.m., the blood sugar result was 500;</p> <p>October 30, at 7:00 a.m., the blood sugar result was 439;</p> <p>November 2, at 5:00 p.m., the blood sugar result was 437;</p> <p>November 13, at 5:00 p.m., the blood sugar result was 418;</p> <p>December 2, at 5:00 p.m., the blood sugar result was 431;</p> <p>December 16, at 7:00 a.m., the blood sugar result was 459.</p> <p>Resident #100's clinical record lacked any documentation of his blood sugar having been rechecked in two hours per physician order when his blood sugar was greater than 400.</p> <p>During an interview, on 12/19/16 at 7:56 a.m., LPN #7 indicated staff document</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2016	
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 blood sugar result on the Medication Administration Record when a blood sugar has been rechecked due to a physician's order or if it was an prn (as needed) result. LPN #7 indicated a nurse progress note would be completed also to document the notification of the physician.</p> <p>During an interview on 12/19/16 at 11:06 a.m., the Director of Nursing indicated she did not have any documentation to provide regarding the rechecking of Resident 100's blood sugar when his blood sugar result was greater than 400.</p> <p>Review of the current, 1/13/16, facility policy, titled "Blood Sugar Monitoring", provided by the Director of Nursing on 12/19/16 at 12:46 p.m., included, but was not limited to, the following:</p> <p>"...1. Check physician's order for blood sugar testing frequency... ...If blood glucose level is above or below parameter range, document the time the physician was notified..."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				