STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	01/31/2017

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00220517. Complaint IN00220517 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Unrelated deficiencies are cited. Survey dates: January 30 and 31, 2017 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census bed type: SNF/NF: 93 Total: 93 Census payor type: Medicare: 6 Medicaid: 85 Other: 2 Total: 93 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC	F 0000		

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

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

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	16.2-3.1. Quality Review was completed by 35984 on February 1, 2017.			
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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			

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	physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			
	Based on record review and interview, the facility failed to ensure the physician was notified when there was a change in condition for 1 of 4 residents reviewed for physician notification. (Resident D) Findings include: The clinical record for Resident D was reviewed on 1/30/2017 at 10:19 a.m. Diagnoses included, but were not limited to, gram negative sepsis, calculus of kidney, dementia, pressure ulcer stage 3 and altered mental status. Review of the shower sheet, dated 1/25/2017, indicated no new skin concern areas. The shower sheet was signed by LPN #1. Review of the weekly skin assessment,	F 0157	MD was notified on 1-30-17 of changes in skin and an order was obtained for a treatment for Res D. Family of Res D was notified on 1-30-17 of changes in skin and of the new order obtained. All residents had skin assessments completed with no new concerns or changes noted. All shower sheets for the past 14 days were checked with no new concerns or changes noted. Nursing staff in-serviced that MD needs notified of any change in condition of a resident including changes in skin. This includes CNAs reporting to nurses any new skin areas noted when completing shower sheet and licensed nursing staff reporting to MD any new skin areas observed. DNS/designee to audit weekly skin assessments to ensure that MD/family has been notified of any new skin concerns. These	02/23/2017

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	dated 1/26/2017, indicated Resident D presented with a 2.5 cm x 1.0 cm yellow discoloration in the pubic area. Review of the shower sheets, dated 1/28/2017, indicated Resident D was observed to have a "red groin". The shower sheet was signed by LPN #1. Review of the nursing notes, dated 1/18/2017 to 1/30/2017, lacked any indication of physician or family notification for the identified skin concerns on 1/26/2017 or 1/28/2017. During an interview on 1/31/2017 at 11:10 a.m., LPN #1 indicated the clinical record lacked any family or physician notification of the new skin concern. LPN #1 indicated Resident D was non ambulatory and was not able to make her needs known. She indicated the nurse should have called the physician to obtain an order for treatment and then completed a nursing note. During an interview on 1/31/2017 and 11:38 a.m., the DNS (Director of Nursing Services) indicated the clinical record lacked appropriate documentation of the skin concerns identified on the shower sheet and the weekly skin assessment. She indicated the family and the physician should have been notified and		audits will be completed 5 x per week x 2 months, 3 x a week x 2 months, then weekly for 2 months. UM/designee to audit shower sheets to ensure MD/Family has been notified of any new skin concerns. Shower sheet audits will be completed 5 x per week x 2 months, 3 x a week x 2 months, then weekly x 2 months. DNS/designee to review previous day nurses notes every business day in clinical start up to ensure any new concerns identified on weekly skin assessments and/or shower sheets have documentation present in the nurses notes with follow up noted. This process is ongoing as part of clinical start up. Results of all audits will be brought to QAPI each month for six months for review and to track for any trends. If any trends identified then audits will be conducted per QAPI Committee recommendations.	

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	treatment orders should have been obtained. Review of a current policy dated 10/20/2016 titled "Clinical Health Status-Change of Condition Guideline" indicated the following: "...Change of Condition-SBAR: The process for identification of change of condition includes gathering objective data and documenting assessment findings, resident/patient response, and physician and family notification. ... Monitoring/Compliance: ... Documentation in the electronic record supports MD/family notification is completed timely. ..." This federal tag relates to Complaints IN00220517. 3.1-5(a)(2)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of			

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	care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on observation, record review and interview, the facility failed to ensure appropriate skin care was provided to 1 of 2 dependent residents reviewed for Activities of Daily Living. (Resident D) Findings include: The clinical record for Resident D was reviewed on 1/30/2017 at 10:19 a.m. Diagnoses included, but were not limited to, gram negative sepsis, calculus of kidney, dementia, pressure ulcer stage 3 and altered mental status. The Medication and Treatment Record for January 2017 was reviewed and indicated a physician order for a dressing change as follows: "Right Ischium Stage 3. Cleanse wound with Normal Saline and pat dry. Pack with Aquacel AG	F 0309	Dressing was immediately applied to open area on Res D and added to CNA assignment sheet to be checked during incontinent care. All residents with any type of wound dressing in the building were checked and all other dressings were noted to be intact. Nursing staff in-serviced that when providing incontinent care they are to check to ensure wound dressing is in place. If no dressing is noted than staff needs to alert the nurse so that dressing can be replaced. Nursing staff was also in-serviced to apply barrier cream to all incontinent residents when giving incontinent care. CNAs were in-serviced to notify nurse of any skin issues including red areas. UM/designee to randomly check 3 residents per day to ensure wound dressings are in place.	02/23/2017

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	skinny ribbon [hydrofiber dressing with silver] and cover with Tegaderm. Change every 3 days." This order was dated 1/25/2017. The last dressing change was documented on 1/29/2017. During an observation of incontinence care on 1/30/2017 at 2:01 p.m., Resident D, was observed to have redness to the buttocks, groin and bilateral inner thigh areas. CNA #8 indicated the resident was incontinent of bowel and bladder and provided the perineal care then placed a clean brief on the resident. No barrier cream or skin treatment was provided. When asked if the resident had an order for barrier cream, the CNA indicated she didn't know and applying cream to the perineal area was something the nurses would do. During the observation no dressing was present on the stage 3 pressure ulcer to the right ischium. The CNA did not informed the nurse the dressing was missing nor did she inform the nurse of the red areas located on the buttocks, groin and inner thigh. Following the incontinence care observation on 1/30/2017 at 2:20 p.m., LPN #1 and LPN #11 went to inspect Resident D's buttocks and perineal area. They both indicated the CNA should have reported the redness to the nurse and should have applied barrier cream to		These audits to be done over all shifts and will be conducted as follows: 3 residents/day 5 times weekly x 2 months, 3 res/day 3 times weekly x 2 months, then 3 res weekly x 2 months. Audit results will be forwarded to QAPI Committee each month for six months to track for any trends. If any trends are identified in QAPI then audits will be conducted per QAPI Committee recommendations. If there are no trends identified then audits will be completed on a prn basis.	

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	the reddened areas. Neither noted the missing dressing to the right ischium. During an interview on 1/31/2017 at 11:38 a.m., the DNS (Director of Nursing Services) indicated the all incontinent residents should have barrier cream applied with incontinent care. She indicated applying barrier cream is a nursing measure and the CNA would be able to apply the cream to any dependent incontinent resident. She inspected Resident D's buttocks, groin and bilateral inner thighs and noted the dressing to the right ischium was missing. The physician orders were reviewed and a new dressing was applied. The DNS indicated the wound packing was present, but the covering was missing. The Nurse Practitioner was present in the facility and informed of the redness to the buttocks, groin and bilateral inner thigh areas and new treatment orders were obtained. The DNS indicated the facility had no guidelines at this time for applying barrier cream to incontinent residents. This federal tag relates to Complaints IN00220517. 3.1-37(a)			