

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

PRINTED: 11/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155187</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/16/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3175 LANCER ST</b> <b>PORTAGE, IN 46368</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00212806 and IN00214408.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00211393 and IN00212333 completed on October 12, 2016.</p> <p>Complaint IN00212806- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00214408- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00211393 - Corrected</p> <p>Complaint IN00212333 - Corrected</p> <p>Survey dates: November 15 &amp; 16, 2016</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Census bed type: SNF/NF: 152 Total: 152</p> <p>Census payor type: Medicare: 14 Medicaid: 125 Other: 13 Total: 152</p> <p>Sample: 10</p>	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

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F 000	Continued From page 1 Golden Living Center Fountainview Place was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00212806 and IN00214408.  Quality review completed by 32883 on 11/17/16.	F 000		