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	10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MUNCIE	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	This survey was for a Recertification and State Licensure Survey. Survey Dates: September 23, 24, 25, 28, 29, 30, October 1, 2015 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census bed type: SNF/NF: 107 Total: 107 Census payor type: Medicare: 6 Medicaid: 86 Other: 15 Total: 107 These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on October 5, 2015.	F 0000		
F 0241 SS=E Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY			

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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	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to provide care and services in a manner to promote and protect resident dignity regarding being seated in the hallway for long periods of time, lengthy meal waits, long waits for assistance to eat and staff terminology for dependent residents for 4 of 4 residents reviewed for dignified care (Residents #41, #87, #2 and #78). Findings include: 1. During a 9/24/15, 7:26 a.m., observation at the Unit-C nursing station, 11 cognitively impaired physically dependent residents were sitting in the hallway by the nursing station, some facing the station, some facing down the hall and others lined up with residents facing the back of the wheelchair of the resident who was before them in line. Country music was playing in the area. None of the residents showed signs of attending to the music. They did not smile, sing along, clap their hands or tap their fingers or toes. Residents #41, #87, #2 and #78 were included in the group of 11.	F 0241	**F-241** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The dignity and respect of individuality will be promoted through an inservice to staff regarding the proper way to address the dependent residents as assisted diners. Dining room assignments have been adjusted to better serve the residents to allow them to receive meals in a timely manner. Meals for assisted diners will be served on the skilled unit dining areas with sensory stimulation activity provided before and after meals. Residents will not be lined up in the hallways for meal times, they will be assisted to the dining area on the unit at meal times. Care plans for residents #2, 78, 41, & 87 have been reviewed and updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:**	10/31/2015

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	During a 9/25/15, 7:20 a.m., observation at the Unit-C nursing station, 15 cognitively impaired physically dependent residents were sitting in the hallway by the nursing station, some facing the station, some facing down the hall and others lined up with residents facing the back of the wheelchair of the resident who was before them in line. There was no form of sensory stimulation offered in the area. Residents #41, #87, #2 and #78 were included in the group of 15. During a 9/28/15, 7:29 a.m., observation at the Unit-C nursing station, 14 cognitively impaired physically dependent residents were sitting in the hallway by the nursing station, some facing the station, some facing down the hall and others lined up with residents facing the back of the wheelchair of the resident who was before them in line. There was no form of sensory stimulation offered in the area. Residents #41, #87, #2 and #78 were included in the group of 14. During a 9/29/15, 6:40 a.m. to 7:51 a.m. observation at the Unit-C nursing station, 11 cognitively impaired physically dependent residents were escorted by staff to sit in the hallway by the nursing station, some facing the station, some		All residents have the potential to be affected by the deficient practice. All staff will be inserviced on the proper way to address residents and meal location changes to better serve residents during meal times. Care plans have been reviewed and updated on all residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An audit of meal timelines and how residents are addressed will be completed daily for one week then weekly for one month and then quarterly thereafter if in compliance. Weekly care plan meetings will be held to ensure care plans are reviewed and updated accordingly. **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; and** The new process will be reviewed in morning meeting and further reviewed monthly at the QAPI meeting. A review of audits will be completed twice weekly to ensure the deficient practice does not	

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	facing down the hall and others lined up with residents facing the back of the wheelchair of the resident who was before them in line. The area lacked any form of sensory stimulation. One resident had a magazine. The residents sat in this position from 34 minutes to 1 hour and 11 minutes. Residents #41, #87, #2 and #78 were included in the group of 11. During a 9/28/15, 7:33 a.m. to 8:45 a.m., observation of the Main Dining Room, 8 physically dependent cognitively impaired residents were seated at the tables waiting for meal service and assistance for periods of 49 minutes to 1 hour and 12 minutes. There was not an event or activity offered at this time. For periods of time during the wait music did play. None of the residents attended to or responded to the music. There were no sensory stimulation materials in the area. The residents sat in their chairs with their eyes closed, their chins to their chests, moved restlessly or snored softly during the wait. Residents #41, #87, #2 and #78 were included in the group of 8. During a 9/28/15, 4:51 p.m. to 6:00 p.m., observation of the Main Dining Room, 8 physically dependent cognitively impaired residents were seated at the tables waiting for meal service and		recur. **By what date the systemic changes will be completed:** October 31, 2015	

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	assistance for periods of 42 minutes to 1 hour. There was not an event or activity offered at this time. For periods of time during the wait music did play. None of the residents attended to or responded to the music. There were no sensory stimulation materials in the area. The residents sat in their chairs with their eyes closed, their chins to their chest, moved restlessly or snored softly during the wait. Residents #41, #87, #2 and #78 were included in the group of 8. During a 9/28/15, 8:25 a.m., observation, RN #7 was overheard in the Main Dining Room saying "... serve the feeders." During a 9/29/15, 7:54 a.m., observation, the Food Services Supervisor was over heard in the Main Dining Room indicating the residents couldn't be served at this time because "they are feeds." 2. Resident #2's clinical record was reviewed on 9/28/15 at 9:44 a.m. Resident #2's diagnoses included, but were not limited to, cerebral palsy, anxiety, blindness in both eyes and major depression. Resident #2 had a 7/25/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitive impaired, rarely or never made			

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	choices, rarely or never understood, was rarely or never understood by others, required staff assistance for transferring, mobility, hygiene and eating, and used a wheelchair (geri chair) for locomotion. Resident #2 had an 8/11/15, care plan problem/need regarding being sad, restless and miserable at times. Approaches to this problem included, but were not limited to, "offer me food and beverages I like." Resident #2 had an 8/11/15, care plan problem/need regarding a function deficit related to mobility impairment. Approaches to this problem included, but were not limited to, "eating assistance of total dependence of one, locomotion assistance total dependence of one and resident is non-ambulatory may use geri chair." Resident #2 had an 8/11/15, care plan problem/need regarding a poor response to others and the environment due to cerebral palsy, intellectual disability and blindness. Approaches to this problem included, but were not limited to, "Use sensory materials during 1:1 [one to one] visits with me." During a 9/28/15, breakfast observation, Resident #2 was escorted in to the Main			

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	Dining Room and seated at the table as if ready to dine at 7:44 a.m. Resident #2's meal was served to her at 8:35 a.m. (51 minutes after being seated at the meal table). During her wait Resident #2 did not have any sensory stimulating materials. She moved about restlessly and occasionally vocalized while waiting. After her meal was placed in front of her at 8:35 a.m., totally dependent Resident #2 was not assisted to eat until 8:38 a.m. (3 minutes with the meal on the table in front of her). During a 9/28/15, dinner observation, Resident #2 was escorted in to the Main Dining Room and seated at the table as if ready to dine at 5:09 p.m. Resident #2's meal was served to her at 5:51 p.m. (42 minutes after being seated at the meal table). During her wait Resident #2 did not have any sensory stimulating materials. She moved about restlessly and occasionally vocalized while waiting. After her meal was placed in front of her at 5:51 p.m., totally dependent Resident #2 was not assisted to eat until 5:53 p.m. (2 minutes with the meal on the table in front of her). During a 9/29/15, observation, Resident #2 was escorted by a staff member and placed in the hallway facing the nurses station at 7:07 a.m. She sat in the			

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	hallway from 7:07 a.m. to 7:50 a.m. (43 minutes). During this 43 minute wait, Resident #2 did not have any form of sensory stimulating materials nor did staff interact with the resident. The resident moved restlessly throughout the entire period. She vocalized from time to time calling with both sounds and crying. 3. Resident #78's clinical record was reviewed on 9/28/15 at 10:08 a.m. Resident #78's diagnoses included, but were not limited to, Lewy Body Dementia, bipolar disorder, anxiety, legal blindness and major depression. Resident #78 had a 8/21/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident could not answer questions for a cognitive assessment because she was rarely or never understood, had moderate cognitive impairment and required assistance for decision making, required staff assistance for transferring, mobility, hygiene and eating and used a wheelchair (geri chair) for locomotion. Resident #78 had an 8/25/15, care plan problem/need regarding inappropriate responses to stimuli. Approaches to this problem included, but were not limited to, "offer activities involving tactile stimulation or manipulation."			

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Resident #78 had an 8/25/15, care plan problem/need regarding vision deficiency and legal blindness. Approaches to this problem included, but were not limited to, "encourage involvement in activities."

Resident #78 had an 8/25/15, care plan problem/need regarding dependence for activities of daily living.

During a 9/28/15, breakfast observation, Resident #78 was escorted in to the Main Dining Room and seated at the table as if ready to dine at 7:36 a.m. Resident #78's meal was served to her at 8:44 a.m. (1 hour and 8 minutes after being seated at the meal table). During her wait, Resident #78 did not have any sensory stimulating materials. The resident closed her eyes, moved her legs about restlessly and occasionally vocalized while waiting.

During a 9/28/15, dinner observation, Resident #78 was escorted in to the Main Dining Room and seated at the table as if ready to dine at 5:01 p.m. Resident #78's meal was served to her at 5:49 p.m. (48 minutes after being seated at the meal table). During her wait, Resident #78 did not have any sensory stimulating materials. The resident closed her eyes, moved her legs about restlessly and

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	occasionally vocalized while waiting. After her meal was placed in front of her at 5:49 p.m., totally dependent Resident #78 was not assisted to eat until 6:01 p.m. (12 minutes with the meal on the table in front of her). During a 9/29/15, observation, Resident #78 was escorted by a staff member and placed in the hallway facing the nurses station at 7:07 a.m. She sat in the hallway from 7:07 a.m. to 7:41 a.m. (34 minutes). During this 34 minute wait, Resident #78 did not have any form of sensory stimulating materials nor did staff interact with the resident. The resident moved her legs up, down, back and forth and bounced them throughout the wait. She periodically vocalized softly. 4. Resident #41's clinical record was reviewed on 9/28/15 at 10:02 a.m. Resident #41's diagnoses included, but were not limited to, dementia with behavioral symptoms, Alzheimer's disease and depression. Resident #41 had a 9/2/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident could not answer questions for a cognitive assessment because she was rarely or never understood, had moderate			

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	cognitive impairment and required assistance for decision making, required staff assistance for transferring, mobility, hygiene and eating and used a wheelchair for locomotion. Resident #41 had a 9/2/15, care plan problem/need regarding her poor response to others and the environment. Approaches to this problem included, but were not limited to, "encourage the resident to maintain eye contact, encourage the resident to make verbal responses and give the resident activities that involve tactile stimulation or manipulation." Resident #41 had a 9/2/15, care plan problem/need regarding the need for assistance with activities of daily living. During a 9/28/15, breakfast observation, Resident #41 was escorted in to the Main Dining Room and seated at the table as if ready to dine at 7:39 a.m. Resident #41's meal was served to her at 8:38 a.m. (59 minutes after being seated at the meal table). During her wait Resident #41 did not have any sensory materials. While waiting she closed her eyes, put her chin to her chest, touched the table and looked around. During a 9/28/15, dinner observation,			

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	Resident #41 was escorted in to the Main Dining Room and seated at the table as if ready to dine at 4:58 p.m. Resident #41's meal was served to her at 5:51 p.m. (53 minutes after being seated at the meal table). During her wait, Resident #41 did not have any sensory materials. While waiting she closed her eyes, put her chin to her chest, touched the table and looked around. After her meal was placed in front of her at 5:51 p.m., Resident #41 did not focus on her food or take a bite of her meal. Resident #41 was not cued or assisted to eat until 5:57 p.m. (6 minutes with the meal on the table in front of her). During a 9/29/15, observation, Resident #41 was escorted by a staff member and placed in the hallway facing the back of another resident's wheelchair at 6:56 a.m. She sat facing the back of another resident's wheelchair from 6:56 a.m. to 7:43 a.m. (47 minutes). During this 47 minute wait, Resident #41 did not have any form of sensory stimulating materials nor did staff interact with the resident. 5. Resident #87's clinical record was reviewed on 9/28/15 at 9:37 a.m. Resident #87's diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbances and major depression.			

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	Resident #87 had a 6/27/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident could not answer questions for a cognitive assessment because she was rarely or never understood, had moderate cognitive impairment and required assistance for decision making, required staff assistance for transferring, mobility, hygiene and eating and used a wheelchair (broda chair) for locomotion. Resident #87 had a 6/27/15, care plan problem/need regarding impaired ability to complete activities of daily living. Approaches to this problem included, but were not limited to, "assist the resident with activities of daily living." During a 9/28/15, breakfast observation, Resident #87 was escorted in to the Main Dining Room and seated at the table as if ready to dine at 7:33 a.m. Resident #87's meal was served to her at 8:39 a.m. (1 hour and 6 minutes after being seated at the meal table). During her wait, Resident #87 did not have any sensory materials. While waiting she closed her eyes and put her chin to her chest. During a 9/28/15, dinner observation, Resident #87 was escorted in to the Main Dining Room and seated at the table as if ready to dine at 5:02 p.m. Resident #87's			

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	meal was served to her at 5:49 p.m. (47 minutes after being seated at the meal table). During her wait Resident #87 did not have any sensory materials. While waiting she closed her eyes, put her chin to her chest, and looked around. After her meal was placed in front of her at 5:49 p.m., Resident #87 was not assisted to eat until 5:54 p.m. (5 minutes with the meal on the table in front of her). During a 9/29/15, observation, Resident #87 was sitting in the hallway facing the nursing station at 6:40 a.m. She sat facing the nursing station until 7:12 a.m. when LPN #4 moved Resident #87's broda chair and placed her facing the treatment cart. She then administered a medication to the resident. She left Resident #87 seated facing the treatment cart and continued passing medications to other residents. Resident #87 sat facing the treatment cart until 7:50 a.m. Resident #87 sat in the hallway facing either the nurse's station or treatment cart for 1 hour and 10 minutes. During this 1 hour and 10 minute wait, Resident #87 did not have any form of sensory stimulating materials. The only staff:resident interaction was the administration of medication. The meal time schedule posted outside the Main Dining Room on 9/23/15 at			

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	8:45 a.m., indicated the following: "Main Dining Room: Breakfast: 7:45 a.m. Lunch: 12:00 p.m. Dinner: 5:45 p.m." The posted meal times were consistent with the "Meal Time" form left on the conference room table for survey review on 9/23/15. A current, 2/2011, facility policy titled "Your Rights as a Nursing Home Resident", provided by the Assistant Director of Nursing on 9/30/15 at 9:10 a.m., indicated: "Basic Rights: You have the right to be treated with respect and dignity in recognition of your individuality and preferences. During a 9/30/15, 1:38 p.m., interview, the Social Services Director indicated residents should be treated with dignity and should not be placed for long periods of time in a location without being involved in a meaningful event or activity. She additionally indicated it was not a cultural custom to sit in hallways or wait for lengthy periods sitting at a dining table. 3.1-3(t)			

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	155687	A. BUILDING 00 B. WING	10/01/2015

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F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure 1 of 2 who met the criteria for choices received showers per their preference. (Resident #100) Findings include: Resident #100's clinical record was reviewed on 9/28/15 at 10:15 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, tremors, and cerebral infarction. The resident had a 8/20/15, admission Minimum Data Set assessment. The assessment indicated the resident had no cognitive impairment related to decision making and was totally dependent with the assistance of two for bathing. The resident's "Bathing Detail Report", printed on 9/28/15 at 11:43 a.m., was left	F 0242	**F-242** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #100 will be asked shower preference for time of day, frequency and type of bath and care will reflect resident preference. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the deficient practice. Staff will be inserviced on resident rights to make choices. Resident shower preference will be placed in the shower book.	10/31/2015

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	on the table in a folder on 9/28/15 at 1:45 p.m., along with his shower sheets for September, 2015. The "Bathing Detail Report" indicated the resident had showers on August 14, 18, 25, September 11 and 26, 2015. There were shower sheets indicating the resident had a shower on September 4, 8, 11, and 26, 2015. The record indicated a seven day period between showers from August 18 to August 25, and 14 days between showers from September 11 to September 26, 2015. Review of the clinical record lacked an indication that the resident refused showers. During an interview with Resident #100 on 9/24/15 at 8:56 a.m., the resident indicated he could not choose how often he received a shower. He indicated he only received one shower a week. During an interview with Resident #100 on 9/29/15 at 12:52 p.m., Resident #100 indicated he would like to have two showers a week on day shift. He indicated he had refused showers when they had tried to give him one at 10:30 or 11:00 p.m. During an interview on 9/29/15 at 12:54 p.m., CNA #5 indicated the resident		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Resident bathing preference will be placed in the shower book and on CNA assignment sheet so staff is aware of the residents shower preference. **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; and** Shower sheet audits will be completed twice weekly for one month and then once a week for two months and then quarterly to ensure the deficient practice does not recur. Additionally, the process will be reviewed in QAPI monthly. **By what date the systemic changes will be completed:** October 31, 2015	

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	occasionally refused to go to the shower. CNA #5 indicated the resident refused his shower if it was when she worked a double. She, then, tried to give him a shower on second shift. She indicated she documented on the shower sheets when he refused his showers. The shower schedule was provided by the Assistant Director of Nursing on 9/30/15 at 9:10 a.m. The schedule indicated the resident was to receive showers on Wednesdays and Saturdays on day shift. The current 2006, "Bath, Shower" procedure was provided by Assistant Director of Nursing on 9/30/15 at 9:10 a.m. The procedure indicated the purpose was to cleanse and refresh the resident, observe the skin, and provide increased circulation. The procedure indicated "Assessment Guidelines: May include, but are not limited to:...Resident's preference for time of day, frequency and type of bath...." 3.1-3(u)(1)			
F 0253 SS=E Bldg. 00	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.			

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	Based on observation, record review and interview, the facility failed to ensure resident rooms were clean, in good repair and odor free for 2 of 12 residents interviewed, 1 of 3 families interviewed (Residents #65, #11 and #122) and 12 of 17 rooms observed for a clean homelike environment. This deficient practice had the potential to affect 23 residents who could reside in the 23 licensed beds (Resident Rooms 101, 124, 125, 132, 133, 203, 206, 216, 217, 218, 223, 231) Findings include: 1. During an interview with Resident #65 on 9/24/15 at 10:47 a.m., she indicated her window needed to be washed. There was a film like coating on the interior side of the window pane and water stains on the exterior side of the window pane making the glass appear hazy. 2. During an interview with Resident #11 on 9/24/15 at 11:04 a.m., she indicated her room had not changed since she was admitted. She indicated the walls had been scraped and gouged and there had been silver duct tape around the heater when she moved in. 3. During a family interview for Resident #122 on 9/25/15 at 10:46 a.m.,	F 0253	**F-253** **What corrective actions will be accomplished for those residents found to have been affected by the Deficient practice?** The resident rooms identified have been cleaned, repaired, and re-waxed. Staff has been in-serviced on how to place Environmental concerns into the Work Order System on the Computer Kiosk. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All resident rooms have the potential to be affected. All rooms have been assigned for deep cleans which will include repairs and re-waxing. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	10/31/2015

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	it was indicated the facility was not clean. The family member indicated the housekeepers did not change their mop water frequently enough and the bathroom had too much urine odor. The family member indicated Resident #122 felt like the bathroom was filthy. 4. The environmental tour was conducted on 9/29/15 from 2:00 p.m. to 2:52 p.m., with the Maintenance Supervisor, the Administrator, Director of Nursing, and the Housekeeping Supervisor present. The following observations and interviews were made during the tour: Room 101 - the outside corner wall of the closet had the plaster chipped away with the metal beading was exposed. There were black scuff marks on the lower portion of the bathroom door. The floor had dark areas. The Housekeeping Supervisor indicated the floor needed to be stripped and rewaxed. The Maintenance Director indicated the staff filled out work orders on the kiosk when they observed areas that need repaired. Room 124 - had several nickel sized areas by the bed where the wallpaper was missing and the drywall was gouged and exposed. The Maintenance Supervisor indicated he thought they were caused by		Environmental rounds will be completed daily for one week, then weekly for one month, and then monthly when in compliance. All results will forwarded to the QAA Committee for review **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;** The new process will be reviewed in morning meeting and further reviewed monthly at the QAPI meeting. A review of audits will be completed twice weekly to ensure the deficient practice does not recur. **By what date the systemic changes will be completed:** October 31, 2015	

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	something hanging from the light switch cord. He indicated some of the gouges were deep and he was not aware of them. Room 125 - the bathroom had a strong urine odor. The Housekeeping Supervisor indicated it was an ongoing problem. Room 132 - the paint was scraped off of the wall behind the chair and the wallpaper was torn and rough to the touch. The threshold to the bathroom had a black build-up of soil on the threshold. The Maintenance Supervisor ran his hand over the area and indicated he could feel the roughness. Room 133 - had a urine odor and the threshold to the bathroom was soiled. The Housekeeping Supervisor indicated all the thresholds needed to be scrubbed. Room 203 - the bathroom floor looked gray and dirty. The vinyl was torn. The Maintenance Supervisor indicated the floor was scheduled to be replaced. Room 206 - the bottom of the bathroom door had black scuff marks. The threshold had a soil build-up. The Housekeeping Supervisor indicated floors were swept and mopped everyday.			

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	Room 216 - the wall by the window bed was scraped and gouged. There was silver duct tape around the heater and an electrical outlet was missing a cover. The Maintenance Supervisor indicated heaters had been replaced and didn't fit the same. He indicated they had to buy sleeves to put around the new heaters and the tape was there temporarily. He indicated he did not have the sleeves when he replaced the units. Room 217 - the bathroom sink was pulled away from the wall. The bathroom door was gouged and rough. The Administrator, Maintenance Supervisor and Housekeeping Supervisor indicated they were not aware of the sink being away from the wall. Room 218 - had paint scraped off the wall above the bed. The Administrator indicated it was from the head of the bed rubbing against it. Room 223 - the window had water marks on the outside glass and a hazy film on the inside glass that could be wiped away. The Administrator and Housekeeping Supervisor indicated the window needed cleaned. The heater cover had missing sections. The Maintenance Supervisor indicated he was not aware of the missing pieces on the			

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	heater and he would replace it. Room 231 - had a broken window blind slat laying on top of the heater. There was silver duct tape around the heating unit. The non-skid floor strips were peeling off the floor by the chair for the bed by the door. The Administrator provided the list of rooms to have new flooring installed on 9/29/15 at 3:35 p.m. Room 203 was not on the list of rooms to receive new flooring. The "Deep Cleaning Schedule" for the month of September was provided by the Administrator on 9/30/15 at 3:05 p.m. The schedule indicated rooms 124 and 125 had been deep cleaned on 9/28/15. The 9/23/15, "Bed Inventory" form, completed by the Administrator, indicated the following: Rooms 101, 124, 125, 132, 133, 206, 216, 217, 218, 223 and 231 were each licensed for 2 beds Room 203 was licensed for 1 bed. Resulting in the possibility of 23 residents residing in the rooms with identified concerns. 3.1-19(f)			

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F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to ensure residents had care plans developed for medically related needs for 2 of 32 residents reviewed for care plan development to address medically related needs (Resident #3 and #23). Findings include: 1. Resident #3's clinical record was reviewed on 9/25/15, 2:39 p.m. Resident #3's diagnoses included, but were not	F 0279	**F-279** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 3 and # 23 care plan have been reviewed and updated. **How other residents having the potential to be affected by the**	10/31/2015

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	limited to, dementia with behavioral disturbances, insomnia, sleep disorder and depression. Resident #3 had a current physician order for Trazodone HCL 50 mg (an antidepressant which can be used as a sleep aid) 1 tablet every 24 hours as needed for insomnia. This order originated 8/22/14. Review of Resident #3's Medication Administration Records for July, August and September 2015 indicated the resident used Trazodone HCL for insomnia on 9/15/15, 8/8/15, 8/15/15, 8/18/15, 7/4/15, 7/8/15, 7/11/15 and 7/22/15. Resident #3's clinical record lacked a care plan regarding insomnia. During a 9/30/15, 1:20 p.m., interview, Unit Manager #11 indicated Resident #3 did not have a care plan for insomnia. 2. The clinical record for Resident #23 was reviewed on 9/28/15 at 10:34 a.m. Diagnoses for Resident #23 included, but were not limited to, Alzheimer's disease, hypertension, and depression. A current, 6/22/15, quarterly Minimum Data Set (MDS) assessment indicated Resident #23 could not answer the		**same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the deficient practice. All resident care plans will be reviewed and updated as appropriate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Weekly care plan meetings and quarterly review of care plans will be implemented to ensure the deficient practice does not recur. **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; and** Care plan audits will be completed weekly for one month and monthly for 3 months and then quarterly and addressed at the QAPI monthly meeting. **By what date the systemic changes will be completed:**	

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	questions for a cognitive assessment because she was rarely or never understood, had a moderate cognitive impairment, required assistance for decision making and received hospice services. A nurses note, dated 12/20/14, indicated the physician saw Resident #23 and a new order for hospice to evaluate and treat was given if the family agreed. A nurses note, dated 12/15/14, indicated the physician from hospice evaluated Resident #23 over the weekend. The physician indicated Resident #23 qualified for hospice care. The clinical record for Resident #23 lacked a health care plan related to hospice services for the resident. During an interview on 9/30/15 at 1:34 p.m., the Social Services Director (SSD) indicated a health care plan related to hospice services for Resident #23 should have been initiated when the resident's status changed. 3.1-35(a)		October 31, 2015	
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP			

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	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview and record review, the facility failed to ensure residents had care plans updated to reflect their current ability and functioning level for 2 of 32 residents reviewed for revision of care plans when indicated (Resident #10 and #23). Finding include: 1. During a 9/24/15, 9:08 a.m., interview RN#6 indicated Resident #10 had fallen twice in the last 30 days. She indicated Resident #10 had fallen on 8/22/15 and 9/1/15. She indicated the resident had slipped or lost his balance when transferring during both events. She indicated Resident #10 had received a skin tear to his elbow during his 8/22/15	F 0280	**F-280** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A comprehensive care plan review has been completed on residents # 10 and #23 and care plans have been updated as appropriate. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the ability to be	10/31/2015

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	fall. Resident #10's clinical record was reviewed on 9/25/15 at 2:36 p.m. Resident #10's current diagnoses included, but were not limited to, dementia, vertigo, dizziness, hypertension and muscle weakness. Resident #10 had a 6/30/15, quarterly, Minimum Data Set assessment which indicated the resident was severely cognitively impaired, rarely or never made safe decisions, was unsteady with transferring from surface to surface and required human assistance to maintain his balance. Resident #10 had a current, 6/30/15, care plan problem/need regarding his risk for falls. Approaches to this problem included, but were not limited to,"educate resident not to begin care without staff near by, educate resident of using the wheelchair while brushing teeth due to safety, educate resident to use call light and/or ask for staff assistance prior to going to the bathroom and encourage resident to use toilet verses urinal in bathroom." During a 9/29/15, 1:57 p.m., interview, when questioned, Unit Manger #1 indicated the approaches which had staff		affected by the deficient practice. A comprehensive review of all resident care plans will be completed and care plans will be updated as appropriate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Weekly care plan meetings will take place and care plans will be examined during quarterly reviewed and updated as appropriate. **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; and** Care plan audits will be completed weekly for one month and monthly for 3 months and then quarterly and addressed at the QAPI monthly meeting. **By what date the systemic changes will be completed?** October 31, 2015	

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	encouraging the resident to remember safety tips were not realistic based on the residents current cognitive status and needed revised. 2. During an observation on 9/24/15 at 7:26 a.m., Resident #23 was sitting in a broda chair in the hallway, tapping her hands on her arms or clapping her hands together in a repetitive, non-purposeful manner. During an observation on 9/25/15 at 7:30 a.m., Resident #23 was in bed with her eyes closed. During an observation 9/29/15 at 7:24 a.m., Resident #23 was sitting in a broda chair in the hallway with her eyes closed. Resident #23 was not observed speaking during the survey dates of 9/23, 9/24, 9/25, 9/28, 9/29, and 9/30. The clinical record for Resident #23 was reviewed on 9/28/15 at 10:34 a.m. Diagnoses for Resident #23 included, but were not limited to, Alzheimer's disease, hypertension, and depression. A current, 6/22/15, quarterly Minimum Data Set (MDS) assessment indicated Resident #23 could not answer the questions for a cognitive assessment because she was rarely or never			

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	understood, had a moderate cognitive impairment, required assistance for decision making and received hospice services. A nurses note, dated 12/10/14, indicated Resident #23 had a recent decline in condition which included she was no longer able to feed herself, no longer able to propel herself, and slower to respond to verbal stimuli. A nurses note, dated 12/15/14, indicated the physician from hospice evaluated Resident #23 over the weekend. The physician indicated Resident #23 qualified for hospice care. Resident #23 had a current, reviewed on 9/22/15, health care focus of depression. The goal for this focus was "I will focus on the future and find one thing I enjoy doing such as working puzzles through next review." During an interview on 9/30/15 at 1:34 p.m., the Social Services Director (SSD) indicated the health care plan related to depression for Resident #23 was not appropriate and should not include "focus on the future...." She indicated the health care plan should have been updated when the resident's status changed.			

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	3.1-35(d)(2)(B)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. A. Based on observation, interview and record review, the facility failed to ensure fall prevention approaches were implemented for 1 of 2 residents reviewed for fall prevention (Resident #10). B. Based on record review and interview, the facility failed to ensure weekly laboratory tests were obtained per physician orders for 2 of 6 residents reviewed for timely labs (Resident #137 and #144). Findings include: A1. During a 9/24/15, 9:08 a.m., interview, RN#6 indicated Resident #10 had fallen twice in the last 30 days. She indicated Resident #10 had fallen on 8/22/15 and 9/1/15. She indicated the resident had slipped or lost his balance when transferring during both events. She indicated Resident #10 had received a skin tear to his elbow during his	F 0282	**F-282** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Staff have been inserviced on the toileting plan and care plan updates for resident #10. Orders for labs have been reviewed for residents #137 and #144 and labs have been obtained based on current orders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the deficient practice. CNA sheets will be updated on all residents to reflect toileting program for each resident. Unit managers will be responsible for ensuring all orders are correctly implemented on all residents through daily review of	10/31/2015

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	8/22/15 fall. Resident #10's clinical record was reviewed on 9/25/15 at 2:36 p.m. Resident #10's current diagnoses included, but were not limited to, dementia, vertigo, dizziness, hypertension and muscle weakness. Resident #10 had a 6/30/15, quarterly, Minimum Data Set assessment which indicated the resident was severely cognitively impaired, rarely or never made safe decisions, was unsteady with transferring from surface to surface and required human assistance to maintain his balance. Resident #10 had a current, 6/30/15, care plan problem/need regarding his risk for falls. Approaches to this problem included, but were not limited to, "non-skid strips applied to the floor by his bed, non-skid strips to the floor by the toilet, wear not skid socks or non-skid footwear, educate resident not to begin care without staff near by, educate resident of using the wheelchair while brushing teeth due to safety, educate resident to use call light and/or ask for staff assistance prior to going to the bathroom and encourage resident to use toilet verses urinal in bathroom and resident to have toileting plan."		new orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All staff will be inserviced on the care plan process and toileting program for all residents in the building. CNA sheets will be updated weekly and weekly care plan meetings will be held to keep resident care plans up to date. **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; and** Audits of care plans and CNA assignment sheets will be completed weekly for one month, then monthly for 3 months and then quarterly thereafter if in compliance and reviewed at QAPI monthly. **By what date the systemic changes will be completed?** October 31, 2015	

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During a 9/28/15, 10:15 a.m., observation, Resident #10's bathroom did not have non-skid strips by the toilet.

During a 9/29/15, 1:53 p.m., observation, Resident #10 was wearing regular socks without shoes. His room did not have non-skid strips in front of the toilet.

During a 9/29/15, 1:57 p.m., observation and interview with Unit Manager #11, she indicated Resident #10 should be wearing non-skid socks or well fitted shoes not regular socks. She indicated Resident #10 did not have non-skid strips in front of his toilet. At this time, she reviewed Resident #10's care plan and indicated these 2 approaches were on his care plan and not currently in place. When questioned, she indicated the approaches which had staff encouraging the resident to remember safety tips were not realistic based on the residents current cognitive status and needed revised. She indicated she did not know Resident #10's current toileting plan, but the information could be found on the computer kiosk used by the CNAs.

During a 9/29/15, 2:05 p.m., interview, CNA #14, who was working on Resident #10's unit, indicated she did not know Resident #10's toileting plan and would

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	have to ask the nurse. She indicated she was not aware of any tool to use to obtain this information. She additionally indicated she did not know of any thing specific to do for Resident #10 regarding fall prevention. She indicated she would ask the nurse as well. During a 9/29/15, 2:11 p.m., interview, CNA #15, who was working on Resident #10's unit, indicated she did not know Resident #10's toileting plan and would need to ask the nurse. She indicated she had no directions or place to look for resident specific toileting programs. A "ACU [Alzheimer's care unit] Assignment sheet-Mid 1", which was provided by LPN #11 on 9/29/15 at 2:08 p.m., indicated Resident #10 was on a toileting plan, but offered no directions regarding the plan. An, undated, facility policy, titled "Strategies To Reduced And/Or Prevent Falls", provided by Unit Manager #11 on 9/30/15 at 1:20 p.m., indicated: "Observe for footwear at time of fall...Make sure resident are wearing well fitted shoes with non-skid soles...Interventions to prevent falls must be communicated to associates and monitor for consistent implementation."			

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	B1. The clinical record for Resident #137 was reviewed on 9/25/15 at 3:25 p.m. Diagnoses for Resident #137 included, but were not limited to, End Stage Renal Disease (ESRD), pancreatic cancer, and anemia. Resident #137 had a current order for a weekly hemoglobin and hematocrit (blood laboratory tests to check anemia). This order was from a Nurse Practitioner's progress note dated 7/22/15. Resident #137 had a current, revised on 8/12/15, health care plan with the focus of ESRD. An intervention for this focus was to obtain laboratory tests as ordered by the physician. Resident #137 had a current, initiated 9/23/15, health care plan with the focus of anemia. An intervention for this focus was to obtain laboratory tests as ordered by the physician. The clinical record for Resident #137 lacked any results for a weekly hemoglobin and hematocrit from 7/22/15 until 9/7/15. During an interview on 9/30/15 at 12:25 p.m., RN #6 indicated if the hemoglobin and hematocrit were ordered weekly then			

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	we would do them at the facility. During an interview on 9/30/15 at 4:22 p.m., the "C" Unit Manager indicated they did not have the weekly hemoglobin and hematocrit laboratory tests from 7/22/15 to 9/7/15. During an interview on 10/1/15 at 7:35 a.m., LPN #1 indicated she did not know what happened with the labs for Resident #137. She indicated the unit manager was responsible for checking orders, but the unit manager had been here less than 2 months. Before that no one person was assigned the task of checking orders, following up on laboratory tests, etc. B2. The clinical record for Resident #144 was reviewed on 9/25/15 at 2:04 p.m. Diagnoses for Resident #144 included, but were not limited to, dementia with behavior disturbance, hypertension, and insomnia. Resident #144 had an order for an urinalysis and urine culture and sensitivity dated 9/12/15. The tests were ordered after Resident #144 had a behavioral episode. Resident #144's clinical record lacked any results for a urinalysis and urine culture and sensitivity ordered 9/12/15.			

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During an interview on 9/30/15 at 10:38 a.m., Unit Manager #11 indicated the order for the urine urinalysis and urine culture and sensitivity for Resident #144 was not in the computerized laboratory site (where staff submit requests for laboratory tests).

During an interview on 9/30/15 at 1:14 p.m., Unit Manager indicated the urinalysis and urine culture and sensitivity for Resident #144 had not been obtained.

Review of the current facility policy, dated 1/6/15, titled "Lab Processing/Tracking Guideline", provided by the Assistant Director of Nursing on 9/30/15 at 4:06 p.m., included but was not limited to the following:

"GUIDELINE STATEMENT: To ensure that Diagnostic tests are processed, ordered, obtained, performed, and results received timely. Test results are communicated to the physician in a timely manner with documentation present in the medical record.

Process/Procedure:

Processing the Physician Order:
1. Enter the Physician Order into the

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	PCC [Point Click Care] system. 2. Place the appropriate order information on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) or otherwise appropriate location. 3. Complete the requisition for the diagnostic test and place it in the lab manual/book or location designated by the facility. 4. Place the information related to the physician order on the 24-hour report form for communication to other shifts and the facility IDT [Interdisciplinary Team]. 5. Enter the resident's name, room umber, diagnostic test ordered, order date and the date due on the Diagnostic Tracking Form (BE554). 6. Place the requisition duplicate in the back of the lab manual/book or designated facility location. Tracking the Physician Order: 1. Record the date testing is done or the specimen is drawn in the date done column of the Diagnostic Tracking Form/or module in Amalga. 2. Record the date the results are received/returned in the date returned column of the tracking from/or module in Amalga. 3. Document the physician notification in the resident's clinical record (progress			

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	notes)...." 3.1-35(g)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and interview, the facility failed to ensure a recommendation to decrease an antipsychotic medication was reviewed by the physician, failed to obtain pulses prior to hypertensive medication administration per physician order, failed	F 0329	**F-329** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	10/31/2015

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	to obtain physician ordered laboratory monitoring for 1 of 5 residents reviewed for unnecessary medications. (Resident #81) Findings include: 1. During an observation on 9/24/15 at 8:59 a.m., Resident #81 was seated at a table in a common area talking to other residents. No maladaptive behaviors observed. During an observation on 9/28/15 at 12:29 p.m., Resident #81 was in bed resting quietly. No maladaptive behaviors observed. During an observation on 9/29/15 at 9:24 a.m., Resident #81 was in bed resting quietly. No maladaptive behaviors observed. The clinical record for Resident #81 was reviewed on 9/28/15 at 8:23 a.m. Diagnoses for Resident #81 included, but were not limited to, unspecified psychosis, hypertension, atrial fibrillation, and diabetes. Current physician orders for Resident #81 included, but were not limited to, the following:		GDR incorporated for resident #81 as appropriate to condition. Staff inserviced on the facility policy "noncontrolled medication order documentation." **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the deficiency. All residents on an antipsychotic medication will be reviewed for a GDR. All NP orders will be countersigned by the physician within 72 hours per facility policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All new medication orders will be reviewed daily by the unit managers. **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; and** New orders will be reviewed daily at clinical start up and audited daily for 2 weeks, then 3 x a week for one month, then monthly for two months, and then quarterly at QAPI	

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	a. Seroquel (an antipsychotic medication) 25 milligrams (mg) by mouth at bedtime. This order was a dose decrease from 50 mg on 9/3/15. b. Lopressor (an antihypertensive medication) 100 mg by mouth every morning and at bed time. Hold for a systolic blood pressure less than 110 or an apical heart rate of less than 55. This order originated 10/16/13. c. Coumadin (a blood thinning medication) 5 mg by mouth in the evening every Tuesday, Thursday and Saturday. This order originated 5/13/15. d. Coumadin 6 mg by mouth in the evening every Sunday, Monday, Wednesday, and Friday. This order originated on 5/13/15. e. PT/INR (Prothrombin Time/International Normalized Ratio- a test to determine the length of time required for blood to clot) laboratory test monthly in the morning. This order originated 10/18/13. Resident #81 had a 6/20/15, quarterly Minimum Data Set (MDS) assessment, and a current 8/28/15, annual MDS which indicated the resident had severe cognitive impairment and never or rarely		thereafter if in compliance. **By what date the systemic changes will be completed?** October 31, 2015	

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	made decision. Both assessments indicated Resident #81 did not have any behaviors, hallucinations or delusions during the assessment periods. Resident #81 had a current, revised on 10/2/14, health care plan with the focus of unspecified psychosis. An intervention for this focus was to administer medications as ordered by the physician. Resident #81 had a current, revised on 10/2/14, health care plan with the focus of impaired cardiovascular status. Interventions for this focus included, but were not limited to, "administer medication as ordered by the physician, and observe the effectiveness of the medications." Resident #81 had a current, revised on 10/2/14, health care plan with the focus of risk for complications related to anticoagulant medication. Interventions for this focus included, but were not limited to, "obtain and monitor lab and/or diagnostic work as ordered by the physician and report the results to the physician with follow-up as indicated." A nurses note, dated 3/27/15, indicated Resident #81 had been seen by the Psychiatric Services Nurse Practitioner.			

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	The Nurse Practitioner recommended decreasing the Seroquel from 50 mg to 25 mg at bedtime. The record lacked any documentation the primary care physician had been notified of this recommendation. A nurses note, dated 9/3/15, indicated new pharmacy recommendations were received for Resident #81. The MD (physician) was aware and a new order received to decrease Seroquel from 50 mg to 25 mg at bedtime. Review of the September, 2015 Medication Administration Record (MAR) for Resident #81 indicated the Seroquel 50 mg at bedtime, ordered on 9/20/14 had been discontinued. A new order for Seroquel 25 mg at bedtime was ordered on 9/3/15. The medication was not reduced until 6 months after the Nurse Practitioner's recommendations. Review of the September, 2015 MAR for Resident #81 lacked any documentation of pulses having been obtained prior to the administration of Lopressor at 7:00 a.m. and 8:00 p.m. The Electronic Medical Record (EMR) for September, 2015 had no documented pulses for the 8:00 p.m. Lopressor medication administration time.			

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(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
	Review of laboratory test results in Resident #81's clinical record on 9/28/15 indicated the last PT/INR was drawn on 8/11/15. During an interview on 9/29/15 at 3:48 p.m., RN #10 indicated when an order had the word "more" beneath the order in the Electronic Medication Administration Record (EMAR), additional information was required (blood pressure, pulse, etc.) or physician instructions (call when or hold if, etc.) were displayed. The EMAR "tells you to do more." The EMAR does not consider the mediation administration complete without the additional information associated with the instructions. During an interview on 9/30/15 at 9:09 a.m., LPN #12 indicated the residents that had many changes with their Coumadin dose were kept in a binder on the medication cart. The residents that had been stable without a lot of changes go straight to their chart after the physician has reviewed the PT/INR. During an interview on 9/30/15 at 9:10 a.m., Unit Manager #11 indicated Resident #81 had not had a PT/INR in September. She indicated routine laboratory tests were entered as weekly or monthly per the physician's order. She			

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	155687	A. BUILDING 00 B. WING	10/01/2015

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	indicated she checked for any missing monthly laboratory tests on the last day of the month. The weekend manager checked for expired laboratory orders. During an interview on 9/30/15 at 9:36 a.m., Unit Manager #11 indicated the recommendations from the Nurse Practitioner or Pharmacy Consultant were given to the physician for review. If the physician agreed with/approved the recommendations a verbal order was received. Then the staff wrote the order and the physician signed the order. She indicated she did not know if the the physician was given the recommendation to decrease the Seroquel for Resident #81. Unit Manager #11 indicated before the medication Lopressor was given a blood pressure and pulse needed to be obtained to determine if the medication should be given or held per physician order. She indicated the EMAR only "asked" for the blood pressure and not the pulse. She indicated the order had been entered incorrectly. The weekend manager worked 12 hours on Friday, Saturday, Sunday, and came in for the Monday morning meetings. She reviewed orders to make sure they were complete, accurate, and entered correctly. The weekend manager had been here approximately 3 months. Before the weekend manager it was the			

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	responsibility of all nursing staff, not assigned to one person, to check orders. During an interview on 9/30/15 at 1:21 p.m., Unit Manager #11 indicated the decrease in Seroquel from 50 mg to 25 mg in March had not been completed for Resident #81. She indicated they could not find the progress note from the Nurse Practitioner which contained the recommendations and was not sure if the physician ever reviewed the recommendations. Review of the current facility policy, revised on 11/2011, titled "NON-CONTROLLED MEDICATION ORDER DOCUMENTATION", provided by the Assistant Director of Nursing on 9/30/15 at 4:06 p.m., included, but was not limited to the following: "Policy... ...G. Receipt of Orders from Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Pharmacists 1) Orders may be accepted from non-physician personnel licensed to work with the resident's physician, if state law permits. 2) The orders must comply with all the legal requirements for a physician's			

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	medication order. 3) The responsible physician countersigns the orders within (72) hours/at next physician visit...." Review of the current facility policy, dated 1/6/15, titled "Lab Processing/Tracking Guideline", provided by the Assistant Director of Nursing on 9/30/15 at 4:06 p.m., included but was not limited to the following: "GUIDELINE STATEMENT: To ensure that Diagnostic tests are processed, ordered, obtained, performed, and results received timely. Test results are communicated to the physician in a timely manner with documentation present in the medical record. Process/Procedure: Processing the Physician Order: 1. Enter the Physician Order into the PCC [Point Click Care] system. 2. Place the appropriate order information on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) or otherwise appropriate location. 3. Complete the requisition for the diagnostic test and place it in the lab manual/book or location designated by the facility.			

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	4. Place the information related to the physician order on the 24-hour report form for communication to other shifts and the facility IDT [Interdisciplinary Team]. 5. Enter the resident's name, room umber, diagnostic test ordered, order date and the date due on the Diagnostic Tracking Form (BE554). 6. Place the requisition duplicate in the back of the lab manual/book or designated facility location. Tracking the Physician Order: 1. Record the date testing is done or the specimen is drawn in the date done column of the Diagnostic Tracking Form/or module in Amalga. 2. Record the date the results are received/returned in the date returned column of the tracking from/or module in Amalga. 3. Document the physician notification in the resident's clinical record (progress notes)...." 3.1-48(b)(2) 3.1-48(a)(3)			
F 0362 SS=E Bldg. 00	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support			

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	personnel competent to carry out the functions of the dietary service. Based on observation, interview and record review, the facility failed to employ sufficient support personnel to ensure meals were served on time for 6 of 7 meals observed (9/23/15 - Breakfast, 9/24/15 - Breakfast, 9/24/15- Lunch, 9/28/15 - Breakfast, 9/28/15 - Lunch and 9/29/15 Breakfast). This deficient practice impacted 3 of 3 residents interviewed regarding timely meals. (Residents #29, #94 and #9). This deficient practice had the potential to impact the 10 residents who ate all their meals in their rooms on the C-Hall and the 31 residents who ate all or part of their meals in the Main Dining Room. Findings include: The meal time schedule posted outside the Main Dining Room on 9/23/15 at 8:45 a.m., indicated the following: " ...C-Hall Breakfast: 7:20 a.m. Lunch: 11:50 a.m. Dinner: 5:30 p.m. Main Dining Room: Breakfast: 7:45 a.m. Lunch: 12:00 p.m. Dinner: 5:45 p.m." The posted meal times were consistent	F 0362	**F-362** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The dignity and respect of individuality will be promoted through an inservice to staff regarding the proper way to address the dependent residents as assisted diners. Dining room assignments have been adjusted to better serve the residents to allow them to receive meals in a timely manner. Meals for assisted diners will be served on the skilled unit dining areas with sensory stimulation activity provided before and after meals. Residents will not be lined up in the hallways for meal times, they will be assisted to the dining area on the unit at meal times. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the deficient practice. All staff will be inserviced on the proper way to address residents and	10/31/2015

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	with the "Meal Time" form left on the conference room table by the administrative staff for surveyor review on 9/23/15. The 2/3/15, 4/7/15, 5/4/15, and 7/7/15 "Resident Council Minutes" indicated residents had concerns with meals not being served in a timely manner. During a 9/23/15, breakfast meal observation, the first meal was served in the Main Dining Room at 8:34 a.m. (45 minutes later than the posted meal time). During a 9/23/15, 8:34 a.m., interview, the Assistant Food Services Supervisor indicated the breakfast meal was scheduled to be served in the Main Dining Room at 7:45 a.m. She indicated the dietary department could not serve meals until nursing staff were present to serve meal trays and assist residents. She indicated lack of nursing staff to distribute meals had been a recent concern. During a 9/23/15, breakfast observation of the C-Hall, hall trays were still being distributed at 8:30 a.m. (1 hour after the scheduled meal time). During a 9/24/15, breakfast observation on the C-Hall, the food cart was delivered		meal location changes to better serve residents during meal times. Care plans have been reviewed and updated on all residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**? An audit of meal timelines and how residents are addressed will be completed daily for one week then weekly for one month and then quarterly thereafter if in compliance. Weekly care plan meetings will be held to ensure care plans are reviewed and updated accordingly. **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; and** The new process will be reviewed in morning meeting and further reviewed monthly at the QAPI meeting. A review of audits will be completed twice weekly to ensure the deficient practice does not recur. **By what date the systemic changes**	

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	to the unit at 7:43 a.m. and the first meal tray was not distributed until 8:15 a.m. (45 minutes after the scheduled meal time). During a 9/24/15, lunch meal observation, the first meal was served in the Main Dining Room at 12:22 p.m. (22 minutes after the posted meal time). During a 9/28/15, breakfast meal observation, the first meal was not served in the Main Dining Room until 8:08 a.m. (23 minutes later than the posted meal time). The first meal tray was served at 8:08 a.m. and the last meal tray was served at 8:49 a.m. (1 hour and 5 minutes after the posted meal time). During a 9/28/15, lunch meal observation, the first meal was not served in the Main Dining Room until 12:30 p.m. (30 minutes after the posted meal time). During a 9/29/15, breakfast meal observation, the first meal was not served in the Main Dining Room until 8:02 p.m. (22 minutes after the posted meal time). During a 9/29/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:36 a.m. The first meal tray was not served until 8:00 a.m. (35		**will be completed:** October 31, 2015	

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	minutes after the posted meal time). At 8:17 a.m., 9 food trays still remained in the food cart (42 minutes after the food cart arrived on the unit and 47 minutes after the posted meal time). The, 7/15 (no day listed), "Food Committee Minutes" indicated residents had concerns with meals not being served on time and nursing staff not being available to distribute trays. During a 9/29/15, 10:26 a.m., interview, Resident #29 indicated he often ate breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were usually served between 8:00 a.m. and 8:30 a.m. (30 minutes to an hour after the scheduled meal time). An 8/21/15, quarterly, Minimum Data Set assessment indicated Resident #29 had no cognitive limitations. During a 9/29/15, 10:28 a.m., interview Resident #94 indicated he normally ate breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were regularly served at 8:00 a.m. to 8:30 a.m. (30 minutes to an hour after the scheduled meal time). An 8/7/15, quarterly, Minimum Data Set assessment indicated Resident #94 had no cognitive limitations.			

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	During a 9/29/15, 10:36 a.m., interview, Resident #9 indicated he normally ate his breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were served from a little after 8:00 a.m. until 9:00 a.m. (30 minutes to an hour and 1/2 after the scheduled meal time). He also indicated meals were regularly served late in the Main Dining room during lunch and dinner. An 7/29/15, significant change, Minimum Data Set assessment indicated Resident #9 had no cognitive limitations. During a 9/29/15, 10:44 a.m., interview, the Food Services Supervisor indicated she was aware of meals not being served on time especially at breakfast. She was aware the length of time between dinner and breakfast sometimes exceeded 14 hours. She indicated the kitchen can not begin serving meals until nursing staff were available to serve trays and assist residents. Lastly, the Food Services Supervisor indicated she had discussed this issue with both the Administrator and the Director of Nursing and no plan of action had been put into place. During a 9/30/15, 3:55 p.m., interview, the Food Services Supervisor indicated 107 of 107 residents who resided in the building ate meals which were prepared in the facility kitchen.			

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	An undated, facility, Main Dining Room seating chart, provided by the Food Serviced Supervisor on 9/30/15 at 3:55 p.m., indicated 41 residents routinely ate meals in the Main Room. An, undated, facility list titled "Lunch and Supper C-Hall", provided by the Food Services Supervisor on 9/30/15 at 3:55 p.m., indicated 10 residents routinely ate lunch and supper in their rooms on C-Hall. When compared with the "Breakfast C-Hall" list it was determined these 10 residents also ate breakfast in their rooms. An, undated, facility list titled "Breakfast C-Hall", provided by the Food Services Supervisor on 9/30/15 at 3:55 p.m., indicated 17 residents routinely ate lunch and supper in their rooms on C-Hall. 3.1-20(h)			
F 0364 SS=D Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.			

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	Based on observation, interview and record review, the facility failed to ensure pleasant palatable food was served for 2 of 3 residents interviewed regarding food palatability, for 1 of 3 families interviewed (Resident #94, #9 and a confidential family) for 6 of 9 months of Food Committee Minutes reviewed and 2 of 9 months of Resident Council Minutes reviewed. (1/2015, 2/2015, 3/2015, 6/2015, 7/2015, 8/2015 and 9/2015). Findings include: The 9/8/15, "Food Committee Minutes" indicated the residents had concerns with dry hard meat which they did not find palatable. The last page of the minutes which contained a survey regarding food satisfaction had not been completed. The 8/4/15, "Food Committee Minutes" indicated the bean soup needed heated more. The last page of the minutes which contained a survey regarding food satisfaction had not been completed. The 7/2015, "Food Committee Minutes" indicated food was sometimes cold. The 3/5/15, "Food Committee Minutes" indicated food was cold and coffee cold. The 2/3/15, "Food Committee Minutes"	F 0364	**F-364** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The dignity and respect of individuality will be promoted through an inservice to staff regarding the proper way to address the dependent residents as assisted diners. Dining room assignments have been adjusted to better serve the residents to allow them to receive meals in a timely manner. Meals for assisted diners will be served on the skilled unit dining areas with sensory stimulation activity provided before and after meals. Residents will not be lined up in the hallways for meal times, they will be assisted to the dining area on the unit at meal times. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the deficient practice. All staff will be inserviced on the proper way to address residents and meal location changes to better serve residents during meal times.	10/31/2015

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	indicated coffee was not hot. The January 2015 (no day), "Food Committee Minutes" indicated food was generally not hot enough. The "Resident Council Minutes" for January 2015 through September 2015 were reviewed. The 9/8/15, "Resident Council Minutes" indicated food was served cold in the Main Dining Room. The 6/2/15, "Resident Council Minutes" indicated food issues were not yet resolved. During a 9/29/15, 10:28 a.m., interview Resident #94 indicated he normally ate breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were regularly served at 8:00 a.m. to 8:30 a.m. (30 minutes to an hour after the scheduled meal time). He indicated food was often cold and the eggs were very cold that morning. An 8/7/15, quarterly, Minimum Data Set assessment indicated Resident #94 had no cognitive limitations. During a 9/29/15, 10:36 a.m., interview, Resident #9 indicated he normally ate his breakfast in his room on C-Hall. He		Care plans have been reviewed and updated on all residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An audit of meal timelines and how residents are addressed will be completed daily for one week then weekly for one month and then quarterly thereafter if in compliance. Weekly care plan meetings will be held to ensure care plans are reviewed and updated accordingly. **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; and** The new process will be reviewed in morning meeting and further reviewed monthly at the QAPI meeting. A review of audits will be completed twice weekly to ensure the deficient practice does not recur. **By what date the systemic changes will be completed:**	

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	indicated C-Hall breakfast trays were served from a little after 8:00 a.m. until 9:00 a.m. (30 minutes to an hour and 1/2 after the scheduled meal time). He indicated food was frequently served cold in both the room and the Main Dining Room. An 7/29/15, significant change, Minimum Data Set assessment indicated Resident #9 had no cognitive limitations. During a 9/25/15, 10:48 a.m., confidential family interview, the family member indicated her loved one did not enjoy the facility's food and complained about it regularly. She indicated the vegetables were often either overcooked or undercooked. During a 9/24/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:43 a.m. and the first meal tray was not distributed until 8:15 a.m. The meals sat on the cart for 27 minutes before meal delivery began. During a 9/29/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:36 a.m. The first meal tray was not served until 8:00 a.m. At 8:17 a.m., 9 food trays still remained in the food cart (42 minutes after the food cart arrived on the unit). A test tray was obtained by the Food		October 31, 2015	

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	Service Supervisor on 9/29/15 at 8:18 a.m. She obtained the test tray from the 8 trays left on the C-Hall meal cart. The food was tested for temperature and taste. The results were as followed: Scrambled eggs -92.7 degrees Fahrenheit (F), the eggs were cold and unpleasant when tasted Toast- the toast was cold when touched and unable to be tested for temperature because it would break apart and not hold the thermometer. Milk- 55.7 F, the milk was luke warm and not pleasant. Juice- 60.3 F, the juice was not cool but had a pleasant taste. The hot cereal was 130 F. The cereal was luke warm but could be eaten. The meal tray rested on a heating pallet. The pallet was cold to the touch. During an interview at this time, the Food Services Supervisor indicated meal trays should be served promptly when they arrived on the unit. She indicated long waits resulted in cold food. Lastly, she indicated the temperatures of the food on the test tray were not acceptable for a			

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	155687	A. BUILDING 00 B. WING	10/01/2015

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	pleasant palatable meal. 3.1-21(a)(2)			
F 0368 SS=E Bldg. 00	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on observation, interview and record review, the facility failed to ensure there was no more than a 14 hour time span between the supper and breakfast meal. This deficient practice impacted 3 of 3 residents interviewed regarding timely meals. (Residents #29, #94 and #9). This deficient practice had the potential to impact the 10 residents who only ate their meals in their rooms on C-Hall and 31 residents who ate all or part of their meals in the Main Dining	F 0368	**F-368** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The dignity and respect of individuality will be promoted through an inservice to staff regarding the proper way to address the dependent residents as assisted diners. Dining room assignments	10/31/2015

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	Room. Findings include: The meal time schedule posted outside the Main Dining Room on 9/23/15 at 8:45 a.m., indicated the following: " ...C-Hall Breakfast: 7:20 a.m. Lunch: 11:50 a.m. Dinner: 5:30 p.m. Main Dining Room: Breakfast: 7:45 a.m. Lunch: 12:00 p.m. Dinner: 5:45 p.m." The posted meal times were consistent with the "Meal Time" form left on the conference room table by administrative staff for surveyor review on 9/23/15. The, 7/15 (no day listed), "Food Committee Minutes" indicated residents had concerns with meals not being served on time and nursing staff not being available to distribute trays. The 2/3/15, 4/7/15, 5/4/15, and 7/7/15 "Resident Council Minutes" indicated residents had concerns with meals not being served in a timely manner. The "Resident Council Minutes" lacked any indication the residents had voted on a period of longer than 14 hours between		have been adjusted to better serve the residents to allow them to receive meals in a timely manner. Meals for assisted diners will be served on the skilled unit dining areas with sensory stimulation activity provided before and after meals. Residents will not be lined up in the hallways for meal times, they will be assisted to the dining area on the unit at meal times. Staff has been inserviced to pass snacks every evening prior to bedtime. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the deficient practice. All staff will be inserviced on the proper way to address residents and meal location changes to better serve residents during meal times. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**? An audit of meal timelines and how residents are addressed will be completed daily for one week then weekly for one month and then	

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	dinner and breakfast. Residents had also indicated evening snacks were not consistently passed to them. During a 9/23/15, breakfast meal observation, the first meal was served in the Main Dining Room at 8:34 a.m. (14 hours and 49 minutes after the scheduled time for the dinner meal). During a 9/23/15, 8:34 a.m., interview the Assistant Food Services Supervisor indicated the breakfast meal was scheduled to be served in the Main Dining Room at 7:45 a.m. She indicated the dietary department could not serve meals until nursing staff were present to serve meal trays and assist residents. She indicated lack of nursing staff to distribute meals had been a recent concern. During a 9/24/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:43 a.m. and the first meal tray was not distributed until 8:15 a.m. (a period of 14 hours and 45 minutes after the scheduled time for dinner). During a 9/28/15, breakfast meal observation, the first meal was not served in the Main Dining Room until 8:08 a.m. (a period of 14 hours and 23 minutes after the scheduled time for dinner).		quarterly thereafter if in compliance. Weekly care plan meetings will be held to ensure care plans are reviewed and updated accordingly. **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; and** The new process will be reviewed in morning meeting and further reviewed monthly at the QAPI meeting. A review of audits will be completed twice weekly to ensure the deficient practice does not recur. **By what date the systemic changes will be completed:** October 31, 2015	

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	During a 9/28/15, dinner observation, the first meal was served at 5:31 p.m. During a 9/29/15, breakfast meal observation, the first meal was not served in the Main Dining Room until 8:02 a.m. (a period of 14 hours and 32 minutes after the pervious dinner). During a 9/29/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:36 a.m. The first meal tray was not served until 8:00 a.m. (a period of 14 hours and 30 minutes since the posted dinner time). During a 9/29/15, 10:26 a.m., interview, Resident #29 indicated he often ate breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were usually served between 8:00 a.m. and 8:30 a.m. (30 minutes to an hour after the scheduled meal time). An 8/21/15, quarterly, Minimum Data Set assessment indicated Resident #29 had no cognitive limitations. During a 9/29/15, 10:28 a.m., interview, Resident #94 indicated he normally ate breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were regularly served at 8:00 a.m. to 8:30 a.m. (30 minutes to an hour after the scheduled meal time). An 8/7/15,			

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	quarterly, Minimum Data Set assessment indicated Resident #94 had no cognitive limitations. During a 9/29/15, 10:36 a.m., interview, Resident #9 indicated he normally ate his breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were served from a little after 8:00 a.m. until 9:00 a.m. (30 minutes to an hour and 1/2 after the scheduled meal time). He also indicated meals are regularly served late in the Main Dining room during lunch and dinner. A 7/29/15, significant change, Minimum Data Set assessment indicated Resident #9 had no cognitive limitations. During a 9/29/15, 10:44 a.m., interview, the Food Services Supervisor indicated, she was aware of meals not being served on time especially at breakfast. She was aware the length of time between dinner and breakfast sometimes exceeded 14 hours. She indicated the kitchen could not begin serving meals until nursing staff were available to serve trays and assist residents. Lastly, the Food Services Supervisor indicated she had discussed this issue with both the Administrator and the Director of Nursing and no plan of action had been put into place.			

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	During a 9/30/15, 3:55 p.m., interview, the Food Services Supervisor indicated 107 of 107 residents who resided in the building ate meals which were prepared in the facility kitchen. An undated, facility, Main Dining Room seating chart, provided by the Food Serviced Supervisor on 9/30/15 at 3:55 p.m., indicated 41 residents routinely ate meals in the Main Room. An, undated, facility listed titled "Breakfast C-Hall", provided by the Food Services Supervisor on 9/30/15 at 3:55 p.m., indicated 17 residents routinely ate lunch and supper in their rooms on C-Hall. An, undated, facility listed titled "Lunch and Supper C-Hall", provided by the Food Services Supervisor on 9/30/15 at 3:55 p.m., indicated 10 residents routinely ate lunch and supper in their rooms on C-Hall. When compared with the "Breakfast C-Hall" list it was determined these 10 residents also ate breakfast in their rooms. A, current, 2011, policy titled "Dining Service Hours", provided by the Assistant Director of Nursing on 9/30/15 at 9:10 a.m., indicated "Post patient dining hours in the Dining Services department.			

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	Include start time and any cart delivery time. Do not exceed 14 hours between the evening meal and breakfast the following day...." 3.1-21(d)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was served under sanitary conditions regarding covering foods while transporting the food in hallways and distribution of clothing protectors. This deficient practice had the potential to impact the 10 residents who ate all their meals in their rooms on the C-Hall and the 31 residents who ate all or part of their meals in the Main Dining Room. Findings include: 1. An observation of the passing of breakfast room trays on Unit "C" was	F 0371	**F-371** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** All staff have been in-serviced that all drinks will now be poured in the kitchen or pantry and will be covered prior to serving as well as that staff will now pass all clothing protectors. Resident #100 likes to assist staff so he will now assist in distributing mail and calling Bingo instead of distributing clothing protectors.	10/31/2015

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	made on 9/24/15 and the following observations were made: 8:14 a.m. LPN #4 moved the food cart and the drink cart in front of the nurse's station. The white and chocolate milk were in half gallon cartons and were poured for each resident when the tray was removed from the cart. 8:15 a.m. LPN #4 removed a tray from the tray cart and poured a glass of milk, placed it on the tray and carried the tray down Hall 2 and into a resident's room. The milk was not covered when carried down the hall. 8:17 a.m. CNA #2 carried a tray with an uncovered glass of white milk white and chocolate milk down Hall 2 to room 215. 8:19 a.m. LPN #4 carried uncovered milk on a tray down Hall 2 to room 219. 8:22 a.m. LPN #4 carried a tray with an uncovered glass of milk down Hall 2 to room 220. 8:25 a.m. LPN #4 carried 2 glasses of uncovered milk on a tray down Hall 2 to room 221 and CNA #5 carried milk & coffee uncovered down Hall 3 to room 228.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected so all drinks will now be poured in the kitchen or pantry and will be covered prior to serving. Staff will now pass all clothing protectors. **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; and** The new process will be reviewed in morning meeting and further reviewed monthly at the QAPI meeting. A review of audits will be completed twice weekly to ensure the deficient practice does not recur. **By what date the systemic changes will be completed?** October 31, 2015	

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	8:31 a.m. LPN #4 carried a tray with milk uncovered down Hall 2 to room 223. 8:33 a.m. CNA #5 carried a tray with 2 glasses of uncovered milk down Hall 3 to room 232. 8:35 a.m. CNA #2 carried a glass of uncovered white milk and uncovered chocolate milk down Hall 3 to room 233. 2. On 9/24/15 at 12:16 p.m., the "C" Unit Manager was observed carrying a room tray with 2 glasses of uncovered chocolate milk to room 224. On 9/28/15 at 8:29 a.m., the tray and drink carts were in front of the Unit "C" nurse's station. The "C" Unit Manager placed an uncovered glass of milk and an uncovered glass of water on a tray and CNA #5 carried the tray down Hall 3 to room 232. During an interview on 9/28/15 at 8:32 a.m., "C" Unit Manager indicated drinks were poured on the unit. She indicated covers were not sent for the drinks once they were poured. Staff were not sent anything to cover the drinks with. During an interview on 9/28/15 at 8:35 a.m., with the Assistant Food Services			

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	Supervisor, she indicated the drinks on room trays should have been covered when carried down the halls. During an interview with the Food Services Supervisor on 9/28/15 at 8:38 a.m., she indicated the drinks should have been covered when carried down the halls on the units and she did not know they were not covered. 3. During an observation on 9/24/15 at 11:52 a.m., Resident #100 propelled himself in his wheelchair into the Main dining room. He reached into a plastic bag sitting on a dining room table and retrieved the clothing protectors. He then placed the clothing protectors on his lap and propelled himself to each table. He handed out clothing protectors to the other residents. Resident #100 was not observed washing his hands, using hand sanitizer or having a barrier between the clothing protectors and his legs. He asked the residents if they would like a clothing protector.			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically			

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	organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to have complete and accurate clinical records in regards to communication between the dialysis center and the facility for 1 of 1 resident reviewed for dialysis. (Resident #137) Findings include: The clinical record for Resident #137 was reviewed on 9/25/15 at 3:25 p.m. Diagnoses for Resident #137 included, but were not limited to, End Stage Renal Disease (ESRD), pancreatic cancer, and anemia. Resident #137 had a current physician order for dialysis on Monday, Wednesday, and Friday. This order originated on 7/1/15. Resident #137 had a current, 7/2/15, health care plan with the focus of ESRD. An intervention for this focus was "Written communication form with review of weights and any changes in condition between dialysis provider and	F 0514	**F-514** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** All dialysis communication forms between the facility and the dialysis center will be fully completed for resident # 137 from this point forward. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** Any resident receiving dialysis has the potential to be affected. Staff will be inserviced on completing the dialysis communication form when a resident leaves the facility to attend dialysis. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Unit managers will be assigned to	10/31/2015

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	living center." The clinical record for Resident #137 lacked dialysis communication forms for 7/6/15, 7/10/15, 7/15/15, 7/27/15, 7/31/15, 8/3/15, 8/5/15, 8/7/15, 8/10/15, 8/12/15, 8/14/15, 8/17/15, 8/31/15, 9/2/15, 9/4/15, 9/7/15, 9/9/15, 9/11/15, 9/14/15, 9/16/15, 9/18/15, 9/21/15, and 9/25/15. The clinical record for Resident #137 contained incomplete dialysis forms dated 7/3/15, 7/13/15, 7/17/15, 7/20/15, 7/24/15, 7/29/15, 8/19/15, 8/21/15, 8/24/15, 8/28/15, and 9/23/15. Additional chart review, on 9/30/15 at 2:49 p.m., was completed of the "dialysis binder" for Resident #137. The binder contained a dialysis communication form, dated 9/28/15, which was incomplete. The clinical record for #137 was missing 23 dialysis communication forms, and had 12 incomplete dialysis communication forms. The record had a total of 35 missing or incomplete dialysis communication forms out of 39 days the resident received dialysis treatments. During an interview on 9/29/15 at 12:46 p.m., Resident #137, who was determined to be interviewable during the		ensure staff complete the dialysis communication form correctly. **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; and** Audit of the dialysis communication forms will be completed 3 x a week for one month, then monthly, then reviewed quarterly at QAPI if in compliance. **By what date the systemic changes will be completed?** October 31, 2015	

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	stage one process, indicated there was a binder he "takes back and forth to dialysis". During an interview on 9/30/15 at 12:25 p.m., LPN #1 and RN #6 both indicated the dialysis communication forms were to go with the resident in the binder. They indicated the facility staff completed the top portion of the form before the resident left for dialysis. The dialysis center completed the bottom portion of the form. The back portion was completed when the resident returned to the facility after dialysis by the facility staff. Review of the current facility policy, reviewed 9/29/15, titled "Dialysis Guideline", provided by the Director of Nursing on 10/1/15 at 7:55 a.m., included, but was not limited to the following: GUIDELINE STATEMENT:...Whether resident receiving hemodialysis are transported out of the center, or receive dialysis in hourse [sic], communication is essential for continuity of care.... ...Communication between the dialysis provider and center staff should include: Written communication including review of daily weights, changes in condition or mood, response to the treatment, and			

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(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
	evaluation of the vascular access site (bleeding at site, patency issues, or signs of infection)..." 3.1-50(a)(1)			
F 0520 SS=E Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview and record review, the facility QAA committee failed to develop and implement a corrective action plan for known concerns with timely meals,	F 0520	**F-520** **What corrective actions will be accomplished for those residents found to have been affected by the**	10/31/2015

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	155687	A. BUILDING 00 B. WING	10/01/2015

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	palatable foods and environmental cleanliness and repair for 2 of 12 residents interviewed, 1 of 3 families interviewed (Residents #65, #11 and #122) and 12 of 17 rooms observed for a clean homelike environment. This deficient practice had the potential to affect 23 residents who could reside in the 23 licensed beds (Resident Rooms 101, 124, 125, 132, 133, 203, 206, 216, 217, 218, 223, 231) and 3 of 3 residents interviewed regarding timely meals. (Residents #29, #94 and #9). This deficient practice had the potential to impact the 10 residents who ate all their meals in their rooms on the C-Hall and the 31 residents who ate all or part of their meals in the Main Dining Room. and 2 of 3 residents interviewed regarding food palatability, for 1 of 3 families interviewed (Resident #94, #9 and a confidential family) for 6 of 9 months of Food Committee Minutes reviewed and 2 of 9 months of Resident Council Minutes reviewed. (1/2015, 2/2015, 3/2015, 6/2015, 7/2015, 8/2015 and 9/2015). Findings include:. 1. The 9/8/15, "Food Committee Minutes" indicated the residents had		**deficient practice?** An ad-hoc QAPI meeting will be held to further identify and correct issues with residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. QAPI meetings will be held monthly to prevent any further deficiencies. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Implementing a culture that involves leadership and seeking input from staff, residents and families through QAPI monthly meetings with interdisciplinary team members and quarterly to include the medical director and pharmacist. **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; and** Issues identified from audit reviews will be addressed at QAPI monthly meetings.	

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	concerns with dry hard meat which they did not find palatable. The last page of the minutes which contained a survey regarding food satisfaction had not been completed. The 8/4/15, "Food Committee Minutes" indicted the bean soup needed heated more. The last page of the minutes which contained a survey regarding food satisfaction had not been completed. The 7/2015, "Food Committee Minutes" indicated food was sometimes cold. The 3/5/15, "Food Committee Minutes" indicated food was cold and coffee cold. The 2/3/15, "Food Committee Minutes" indicated coffle was not hot. The January 2015 (no day), "Food Committee Minutes" indicated food was generally not hot enough. The "Resident Council Minutes" for January 2015 through September 2015 were reviewed. The 9/8/15, "Resident Council Minutes" indicated food was served cold in the Main Dining Room. The 6/2/15, "Resident Council Minutes"		**By what date the systemic changes will be completed?** October 31, 2015	

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	indicated food issued were not yet resolved. During a 9/29/15, 10:28 a.m., interview Resident #94 indicated he normally ate breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were regularly served at 8:00 a.m. to 8:30 a.m. (30 minutes to an hour after the scheduled meal time). He indicated food was often cold and the eggs were very cold that morning. An 8/7/15, quarterly, Minimum Data Set assessment indicated Resident #94 had no cognitive limitations. During a 9/29/15, 10:36 a.m., interview, Resident #9 indicated he normally ate his breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were served from a little after 8:00 a.m. until 9:00 a.m. (30 minutes to an hour and 1/2 after the scheduled meal time). He indicated food was frequently served cold in both the room and the Main Dining Room. An 7/29/15, significant change, Minimum Data Set assessment indicated Resident #9 had no cognitive limitations. During a 9/25/15, 10:48 a.m., confidential family interview, the family member indicated her loved one did not enjoy the facility's food and complained about it regularly. She indicated the			

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	vegetables were often either overcooked or undercooked. During a 9/24/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:43 a.m. and the first meal tray was not distributed until 8:15 a.m. The meals sat on the cart for 27 minutes before meal delivery began. During a 9/29/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:36 a.m. The first meal tray was not served until 8:00 a.m. At 8:17 a.m., 9 food trays still remained in the food cart (42 minutes after the food cart arrived on the unit). A test tray was obtained by the Food Service Supervisor on 9/29/15 at 8:18 a.m. She obtained the test tray from the 8 trays left on the C-Hall meal cart. The food was tested for temperature and taste. The results were as followed: Scrambled eggs -92.7 degrees Fahrenheit (F), the eggs were cold and unpleasant when tasted Toast- the toast was cold when touched and unable to be tested for temperature because it would break apart and not hold the thermometer.			

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	Milk- 55.7 F, the milk was luke warm and not pleasant. Juice- 60.3 F, the juice was not cool but had a pleasant taste. The hot cereal was 130 F. The cereal was luke warm but could be eaten. The meal tray rested on a heating pallet. The pallet was cold to the touch. During an interview at this time, the Food Services Supervisor indicated meal tray should be served promptly when they arrive on the unit. She indicated long waits resulted in cold food. Lastly, she indicated the temperatures of the food on the test tray were not acceptable for a pleasant palatable meal. 2. The meal time schedule posted outside the Main Dining Room on 9/23/15 at 8:45 a.m., indicated the following: " ...C-Hall Breakfast: 7:20 a.m. Lunch: 11:50 a.m. Dinner: 5:30 p.m. Main Dining Room: Breakfast: 7:45 a.m. Lunch: 12:00 p.m. Dinner: 5:45 p.m."			

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	The posted meal times were consistent with the "Meal Time" form left on the conference room table by the administrative staff for surveyor review on 9/23/15. The, 7/15 (no day listed), "Food Committee Minutes" indicated residents had concerns with meals not being served on time and nursing staff not being available to distribute trays. The, 7/7/15, 5/4/15, 4/7/15 and 2/3/15 "Resident Council Minutes" indicated residents had concerns with meals not being served in a timely manner. During a 9/23/15, breakfast meal observation, the first meal was served in the Main Dining Room at 8:34 a.m. (45 minutes later than the posted meal time). During a 9/23/15, 8:34 a.m., interview the Assistant Food Services Supervisor indicated the breakfast meal was scheduled to be served in the Main Dining Room at 7:45 a.m. She indicated the dietary department could not serve meals until nursing staff were present to serve meal trays and assist residents. She indicated lack of nursing staff to distribute meals had been a recent concern.			

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	During a 9/23/15, breakfast observation of the C-Hall, hall trays were still being distributed at 8:30 a.m. (1 hour after the scheduled meal time). During a 9/24/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:43 a.m. and the first meal tray was not distributed until 8:15 a.m. (45 minutes after the scheduled meal time). During a 9/24/15, lunch meal observation, the first meal was served in the Main Dining Room at 12:22 p.m. (22 minutes after the posted meal time). During a 9/28/15, breakfast meal observation, the first meal was not served in the Main Dining Room until 8:08 a.m. (23 minutes later than the posted meal time). The first meal tray was served at 8:08 a.m. and the last meal tray was served at 8:49 a.m. (1 hour and 5 minutes after the posted meal time). During a 9/28/15, lunch meal observation, the first meal was not served in the Main Dining Room until 12:30 p.m. (30 minutes after the posted meal time). During a 9/29/15, breakfast meal observation, the first meal was not served			

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	in the Main Dining Room until 8:02 p.m. (22 minutes after the posted meal time). During a 9/29/15, breakfast observation on the C-Hall, the food cart was delivered to the unit at 7:36 a.m. The first meal tray was not served until 8:00 a.m. (35 minutes after the posted meal time). At 8:17 a.m., 9 food trays still remained in the food cart (42 minutes after the food cart arrived on the unit and 47 minutes after the posted meal time). The, 7/15 (no day listed), "Food Committee Minutes" indicated residents had concerns with meals not being served on time and nursing staff not being available to distribute trays. The, 7/7/15, 5/4/15, 4/7/15 and 2/3/15 "Resident Council Minutes" indicated residents had concerns with meals not being served in a timely manner. During a 9/29/15, 10:26 a.m., interview, Resident #29 indicated he often ate breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were usually served between 8:00 a.m. and 8:30 a.m. (30 minutes to an hour after the scheduled meal time). An 8/21/15, quarterly, Minimum Data Set assessment indicated Resident #29 had no cognitive limitations.			

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	During a 9/29/15, 10:28 a.m., interview Resident #94 indicated he normally ate breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were regularly served at 8:00 a.m. to 8:30 a.m. (30 minutes to an hour after the scheduled meal time). An 8/7/15, quarterly, Minimum Data Set assessment indicated Resident #94 had no cognitive limitations. During a 9/29/15, 10:36 a.m., interview, Resident #9 indicated he normally ate his breakfast in his room on C-Hall. He indicated C-Hall breakfast trays were served from a little after 8:00 a.m. until 9:00 a.m. (30 minutes to an hour and 1/2 after the scheduled meal time). He also indicated meals are regularly served late in the Main Dining room during lunch and dinner. An 7/29/15, significant change, Minimum Data Set assessment indicated Resident #9 had no cognitive limitations. During a 9/29/15, 10:44 a.m., interview, the Food Services Supervisor indicated, she was aware of meals not being served on time especially at breakfast. She was aware the length of time between dinner and breakfast at sometimes exceeded 14 hours. She indicated the kitchen can not begin serving meals until nursing staff			

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	were available to serve trays and assist residents. Lastly, the Food Services Supervisor indicated she had discussed this issue with both the Administrator and the Director of Nursing and no plan of action had been put into place. During a 9/30/15, 3:55 p.m., interview, the Food Services Supervisor indicated 107 of 107 residents who resided in the building ate meals which were prepared in the facility kitchen. An undated, facility, Main Dining Room seating chart, provided by the Food Serviced Supervisor on 9/30/15 at 3:55 p.m., indicated 41 residents routinely ate meals in the Main Room. An, undated, facility list titled "Lunch and Supper C-Hall", provided by the Food Services Supervisor on 9/30/15 at 3:55 p.m., indicated 10 residents routinely ate lunch and supper in their rooms on C-Hall. When compared with the "Breakfast C-Hall" list it was determined these 10 residents also ate breakfast in their rooms. An, undated, facility list titled "Breakfast C-Hall", provided by the Food Services Supervisor on 9/30/15 at 3:55 p.m., indicated 17 residents routinely ate lunch and supper in their rooms on C-Hall.			

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	3. During an interview with resident #65 on 9/24/15 at 10:47 a.m., she indicated her window needed to washed. There was a film like coating on the interior side of the window pane and water stains on the exterior side of the window pane making the glass appear hazy. During an interview with resident #11 on 9/24/15 at 11:04 a.m., she indicated her room had not changed since she was admitted. She indicated the walls had been scraped and gouged and there had been silver duct tape around the heater when she moved in. During a family interview for Resident #122 on 9/25/15 at 10:46 a.m., it was indicated the facility was not clean. The family member indicated the housekeepers did not change their mop water frequently enough and the bathroom had too much urine odor. The family member indicated Resident #122 felt like the bathroom was filthy. 4. The environmental tour was conducted on 9/29/15 from 2:00 p.m. to 2:52 p.m., with the Maintenance Supervisor, the Administrator, Director of Nursing, and the Housekeeping Supervisor present. The following observations and interviews were made			

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	during the tour: Room 101 - the outside corner wall of the closet had the plaster chipped away with the metal beading was exposed and there were black scuff marks on the lower portion of the bathroom door. The floor had dark areas. The Housekeeping Supervisor indicated the floor needed to be stripped and rewaxed. The Maintenance Director indicated the staff fill out work orders on the kiosk when they observe areas that need repaired. Room 124 - had several nickel sized areas by the bed where the wallpaper is missing and the drywall is gouged and exposed. The Maintenance Supervisor indicated he thought they were caused by something hanging from the light switch cord. He indicated some of the gouges were deep and he was not aware of them. Room 125 - the bathroom had a strong urine odor. The Housekeeping Supervisor indicated it was an ongoing problem. Room 132 - the paint was scraped off of the wall behind the chair and the wallpaper was torn and rough to the touch. The threshold to the bathroom had a black build-up of soil on the threshold. The Maintenance Supervisor			

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	ran his hand over the area and indicated he could feel the roughness. Room 133 - had a urine odor and the threshold to the bathroom was soiled. The Housekeeping Supervisor indicated all the thresholds needed to be scrubbed. Room 203 - the bathroom floor looked was gray and dirty looking and the vinyl was torn. The Maintenance Supervisor indicated the floor was scheduled to be replaced. Room 206 - the bottom of the bathroom door had black scuff marks and the threshold had a soil build-up. The Housekeeping Supervisor indicated floors are swept and mopped everyday. Room 216 - the wall by the window bed was scraped and gouged, there was silver duct tape around the heater and an electrical outlet was missing a cover. The Maintenance Supervisor indicated heaters had been replaced and didn't fit the same. He indicated they had to buy sleeves to put around the new heaters and the tape is there temporarily. He indicated he did not have the sleeves when he replaced the units. Room 217 - the bathroom sink was pulled away from the wall. The			

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	bathroom door was gouged and rough. The Administrator, Maintenance Supervisor and Housekeeping Supervisor indicated they were not aware of the sink being away from the wall. Room 218 - had paint scraped off the wall above the bed. The Administrator indicated it was from the head of the bed rubbing against it. Room 223 - the window had water marks on the outside glass and a hazy film on the inside glass that could be wiped away. The Administrator and Housekeeping Supervisor indicated the window needed cleaned. The heater cover had missing sections. The Maintenance Supervisor indicated he was not aware of the missing pieces on the heater and he would replace it. Room 231 - had a broken window blind slat laying on top of heater, there was silver duct tape around the heating unit and the non-skid floor strips were peeling off the floor by the chair for the bed by the door. The Administrator provided the list of rooms to have new flooring installed on 9/29/15 at 3:35 p.m., room 203 was not on the list of rooms to receive new flooring.			

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The "Deep Cleaning Schedule" for the month of September was provided by the Administrator on 9/30/15 at 3:05 p.m. The schedule indicated rooms 124 and 125 had been deep cleaned on 9/28/15.

The 9/23/15, "Bed Inventory" form, completed by the Administrator, indicated the following:
Rooms 101, 124, 125, 132, 133, 206, 216, 217, 218, 223 and 231 were each licensed for 2 beds
Room 203 was licensed for 1 bed.
Resulting in the possibility of 23 resident residing in the rooms with identified concerns.

During a 9/30/15, 2:26 p.m., interview, the Administrator indicated the QAA committee reviewed and responded to resident council concerns and did monthly walk through of the environment. She indicated identified care concerns were used to develop and implement corrective action plans. At this time, a request for corrective action plans to address environmental cleanliness concerns, timely meal service and palatable foods was requested for review. Both issues could have been identified by the QAA committee using resident council minutes, food council minutes and environmental walk

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	10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MUNCIE	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
	throughs. No further information was presented as of exit on 10/1/15 at 8:10 a.m.			