STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	01/28/2016

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00191532, IN00191509 and IN00191373. Complaint IN00191532- Substantiated. Federal/State deficiency related to the allegation is cited at F500. Complaint IN00191509 - Unsubstantiated due to lack of evidence. Complaint IN00191373 - Unsubstantiated due to lack of evidence. Unrelated deficiencies are cited. Survey date: January 26, 27 and 28, 2016. Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census bed type: SNF/NF: 103 Total: 103 Census payor type: Medicare: 5 Medicaid: 85 Other: 13	F 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, the plan of correction is not an admission that a deficiency existed or that one was cited correctly. The plan or correction is being submitted to meet state and federal law Golden Living Center respectfully request paper compliance to clear these findings	

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

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	Total: 103 Sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3-1. QR completed by 11474 on February 1, 2016.			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure physician orders were accurately transcribed for 1 of 5 residents reviewed for physician orders. (Resident D) Findings include: Resident D's clinical record was reviewed on 1/26/16 at 3:22 p.m. Diagnoses included, but were not limited to,	F 0309	It is the practice of the facility to provide the necessary care and services to attain or maintain the highest practicable physical mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D had an order written for a dry dressing per her request to physician for	02/28/2016

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	post-laminectomy, hyperlipidemia, diabetes mellitus and hypothyroidism. The hospital post discharge orders, dated 1/18/16, indicated "Remove dressing and shower, Tuesday, 01/19." Review of the January Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated no order was put into the computer related to removing the dressing on 1/19/16. Review of a progress note, dated 1/18/16 at 5:30 p.m., indicated "...Lumbar spine incision measuring 20 cm x 0.2 cm with 15 staples intact with no redness or drainage. Dressing covering staples reinforced...." A progress note, dated 1/19/16 at 1:18 a.m., indicated "Drsg [dressing] D/I [dry/intact] to mid back, scant amt [amount] of dried drng [drainage] remains on drsg...." A progress note, dated 1/20/16 at 4:45 p.m., indicated "...staples to lower back clean dry and intact with some mild redness to lower area of incision. Incision...new dressing applied to back." A progress note, dated 1/21/16 at 10:48		comfort on 1/27/16 and was discharged home on 1/29/16 due to meeting therapy goals. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential of being affected 3. 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 admissions will require a double check with 2 nurse signatures on admitting orders to ensure they are transcribed accurately 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie , what quality assurance program will be put into place? Unit Managers during morning clinical start-up will review all orders to ensure they are transcribed properly and check for 2 nurse signatures on all new admission records Licensed nurses will b re-inserviced on accurately transcribing orders and the new procedure of requiring 2 signatures. Unit Managers will utilize a QA tool and report daily findings to ADNS/DNS to report findings of audits to QA Committee monthly times three and quarterly thereafter. 5. What date the systemic changes will be completed Date of Compliance 2/28/16	

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	a.m., indicated "...staples to back with scant amount of serrrousage [sic] drainage noted." A progress note, dated 1/22/16 at 10:52 a.m., indicated "...clean dry and intact with scant amount of drainage noted...." During an interview on 1/27/16 at 1:05 p.m., RN #1 indicated she was unaware of the dressing order. She indicated she was the admitting nurse for Resident D. Review of a current care plan, dated 1/18/16, indicated Resident D had a problem related to edema to "altered skin integrity non pressure related to: Surgical wound." The interventions included, but were not limited to, "treatment per order." 3.1-37(a)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection			

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	Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on interview and record review, the facility failed to ensure all residents received a Purified Protein Derivative (PPD) test on admission for 1 of 3 residents reviewed for infection control practices (Resident D). Findings include: Resident D's clinical record was reviewed on 1/26/16 at 3:22 p.m. Diagnoses included, but were not limited to,	F 0441	It is the practice of the facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D was discharged home on 1/29/16 2)	02/28/2016

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	post-laminectomy, hyperlipidemia, diabetes mellitus and hypothyroidism. Review of the January Medication Administration Record (MAR) indicated Resident D was admitted to the facility on 1/18/16. An order, dated 1/18/16, indicated "Tubersol Solution 5 UNIT/0.1ML...Inject 0.1 mg intradermally one time only for admit for 1 day...." The MAR did not indicate the order had been completed. During an interview on 1/27/16 at 1:05 p.m., RN #1 indicated she did not give the PPD to Resident D on admission. She indicated she had the resident for about 45 minutes before leaving for the day. During an interview on 1/27/16 at 1:30 p.m., the Assistant Director of Nursing (ADON), indicated the admitting nurse should have given the PPD and she did not. A facility policy, dated 12/01/14, titled "Tuberculosis, Screening Resident for" was provided by the Director of Nursing (DON) on 1/27/16 at 4:00 p.m. It indicated the following: "POLICY STATEMENT: This facility shall screen all residents for		How other residents having the potential to affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential of being affected 3) 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 admissions will require a double check with 2 nurse signatures on admitting orders to ensure they are transcribed properly and that the PPD immunizations are accurately inputted into the computer to show up on electronic MAR for administration 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? Unit Managers will check accuracy of completion of PPD's both annual and new admissions during clinical start-up Licensed staff will be re-inserviced on properly administering PPD immunization orders into PCC Medical Records will complete an audit on clinical record for all new admission to ensure PPD's have been administered and documented on the immunization record utilizing a QA tool Medical Records will report findings of audits to the QA Committee monthly times three and quarterly, thereafter 5) By what date the systemic changes will be	

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	tuberculosis infections and disease (TB). Individual with active TB disease shall be isolated from other residents and ancillary staff, and transported to an appropriate care facility as soon as possible. ...Policy Interpretation and Implementation Any resident without a documented negative TST, BAMT or CXR within the previous 12 months will receive a baseline (two-step) TST or (one-step) BAMT upon admission. If the first TST is negative, a follow-up TST will be administered 1 to 3 weeks after the initial test is read.... ...Screening of new admission or readmissions for Tuberculosis infection and disease will be in compliance with State regulations." 3.1-18(a)		completed? Date of compliance will be 2/28/16	
F 0500 SS=D Bldg. 00	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement			

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	described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. Based on interview and record review, the facility failed to provide routine podiatry services for 1 of 3 residents reviewed for nail care (Resident C). Findings include: The clinical record for Resident C was reviewed on 1/26/16 at 11:15 a.m. Diagnoses included, but were not limited to, dementia without behaviors, hypertension, depression and osteoporosis. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/21/15, indicated Resident C was severely cognitively impaired. Review of the podiatry consent, dated and signed on 10/23/13, indicated the Power of Attorney (POA) agreed to podiatry service and treatment for Resident C. The consent indicated Resident C was private pay. Review of a podiatry consult note, dated	F 0500	It is the practice of the facility to provide outside professional resources/services to the residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph(h) (2) of this section 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident C was examined and received podiatry services on 12/22/15 and is scheduled to be seen again on March 11, 2016. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? A 100% audit of all current residents files was performed. 3) What measures will be put into place what systemic changes will be made to ensure that the deficient practice does not recur? Social Service Directors will utilize a QA tool to monitor new orders and consents daily.	02/28/2016

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	12/22/15, indicated "New patient seen at request of, self. Patient also seen for, painful thick toenails on both feet. Pain most noted, while in bed from pressure of bed sheets. Patient also seen for initial assessment at today's visit...." A current health care plan, initiated 10/24/15 and updated on 11/24/15, indicated Resident C had a physical functioning deficit related to self care impairment. Interventions included, but were not limited to, "assist resident with combing hair, assist with oral care and inspect skin with care." During an interview on 1/27/16 at 4:20 p.m., the Alzheimer's Care Unit (ACU) Manager indicated he thought Resident C was a private pay on admission and the POA wanted to wait since Medicaid was pending. He indicated he was the person who kept track of what resident was seen by whom and when they were seen. Review of a current facility policy, dated 02/19/15, provided by the Assistant Director of Nursing (ADON) on 1/27/16 at 2:10 p.m., titled "Resident Rights" indicated the following: "The Resident has a right to a dignified existence, self-determination, and communication with, and access to,		4) How the corrective actions will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? Social Service Directors will report findings of audits to QA Committee monthly for three months and then quarterly thereafter 5) What date the systemic changes will be completed? Date of compliance will be 2/28/16	

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	persons and services inside and outside the Facility. The Resident has the right to be fully informed in advance about care and treatment and any changes in that care or treatment that may affect the Resident's well-being." This Federal tag related to Complaint IN00191532. 3.1-13(m)(2)			
F 9999 Bldg. 00	STATE RULES: 3.1-14 PERSONNEL (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees	F 9999	It is the practice of this facility to complete tuberculin skin tests prior to resident contact and to maintain employee files to include the tuberculin skin test results, orientation to the facility, specific job skills and mandated education What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A 100% audit of all current employee records was performed using the employee record audit toll provided by the ISDH to identify any missing items. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?	02/28/2016

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	and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test during the preceding twelve (12) months, the baseline tuberculin skin test should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure employees received PPD testing within the required time limit for 5 of 8 employees reviewed. (CNA #10, LPN # 11, LPN # 12, LPN #13, CNA #14) Findings include: The employee record review was completed on 1/28/16 at 2:53 p.m. The review of 8 employee records indicated 3 employee records lacked any tuberculin skin testing documentation and 2 employee records indicated the second step was not given within the required		All records had the potential to be affected 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The identified items have been placed in the employees files. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? The Director of Clinical Education will complete an audit of all new hires files each Friday Audit results will be reported the Executive Director and QA Committee for review each month 5) What date will the systemic changes be completed? Compliance will be completed by 2/28/16	

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	time limit of 14-21 days. Review of CNA #10's employee record indicated the first step PPD (tuberculin skin test) was given on 10/8/15 and the second step PPD was given on 11/23/15, 31 days after the first step was given. Review of LPN #11's employee record indicated the first step PPD was given on 12/17/15 and the second step PPD was given on 1/12/16, 26 days after the first step was given. Review of LPN #12's employee record indicated the record lacked any documentation of a new hire PPD being given. Review of LPN #13's employee record indicated the record lacked any documentation of a new hire PPD being given. Review of CNA #14's employee record indicated the record lacked any documentation of a new hire PPD being given. During an interview on 1/28/16 at 10:30 a.m., the Clinical Educator indicated the employee records were incomplete. The Clinical Educator was unable to provide any further information regarding the			

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	missing documentation. 3.1-14 PERSONNEL (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (g) Signed acknowledgement of orientation to residents' rights. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure 4 of 8 employees, reviewed, received required education related to residents' rights and abuse. (CNA #10, LPN #12, LPN # 13, CNA #14) Findings include: The employee record review was completed on 1/28/16 at 2:53 p.m. The review of 8 employee records indicated 4 employee records lacked documented education related to residents' rights and abuse. Review of CNA #10's employee record			

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	indicated no education related to residents' rights or abuse was given. No signed acknowledgement of orientation to residents' rights was present. Review of LPN #12's employee record indicated no education related to residents' rights or abuse was given. No signed acknowledgement of orientation to residents' rights was present. Review of LPN #13's employee record indicated no education related to residents' rights or abuse was given. No signed acknowledgement of orientation to residents' rights was present. Review of CNA #14's employee record indicated no education related to residents' rights or abuse was given. No signed acknowledgement of orientation to residents' rights was present. During an interview on 1/28/16 at 10:30 a.m., the Clinical Educator indicated the employee records were incomplete. The Clinical Educator was unable to provide any further information regarding the missing documentation. 3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have			

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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
	regular contact with residents shall have a minimum of six (6) hours of dementia training within six (6) months of initial employment, to within thirty (30) days for personnel signed to the Alzheimer's and dementia specialty care units, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure employees received required education related to the care of residents with dementia for 4 of 8 employees reviewed. (CNA# 10, LPN# 12, LPN# 13, CNA #14) Findings include: The employee record review was completed on 1/28/16 at 2:53 p.m. The review of 8 employee records indicated 4 employee records lacked documentation of dementia training. The four employees were hired between 10/9/15 and 10/14/15. Additional information regarding the missing dementia training documentation was requested from the Clinical Educator.			

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Review of CNA #10's employee record indicated no education related to care of residents with dementia was provided.

Review of LPN #12's employee record indicated no education related to care of residents with dementia was provided.

Review of LPN #13's employee record indicated no education related to care of residents with dementia was provided.

Review of CNA #14's employee record indicated no education related to care of residents with dementia was provided.

During an interview on 1/28/16 at 10:30 a.m., the Clinical Educator indicated the employee records were incomplete. The Clinical Educator was unable to provide any further information regarding the missing documentation.

During an interview on 1/28/16 at 3:13 p.m., the Director of Nursing and Assistant Director of Nursing indicated the four employees, CNA #10, LPN #12, LPN #13 and CNA #14, had worked on the dementia specialty care unit.

During an interview on 1/28/16 at 3:30 p.m., the Clinical Educator, Administrator, Director of Nursing and

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	the Assistant Director of Nursing indicated the documentation of the dementia training could not be located. No further information was available or provided.			