STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING _____ B. WING _____	R-C 12/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the PSR completed on 10/1/15 to the Investigation of Complaint IN00179466 investigated on 8/27/15.

This visit was done in conjunction with the PSR to the PSR completed on 10/1/15 to the Investigation of Complaint IN00176471, IN00177395, IN00177742, and IN00177997 investigated on 7/16/15.

This visit was done in conjunction with the PSR to the Investigation of Complaint IN00181613 investigated on 10/1/15.

This visit was done in conjunction with the PSR to the Recertification and State Licensure survey and the Investigation of Complaint IN00184290 completed on 10/30/15.

Complaint IN00179466: Corrected.

Survey dates: December 7 & 8, 2015.

Facility number: 000098
Provider number: 155187
AIM number: 100290980

Census bed type:
SNF/NF: 127
Total: 127

Census payor type:
Medicare: 8
Medicaid: 106
Other: 13
Total: 127

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING _____ B. WING _____	R-C 12/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
{F 000}	Continued From page 1 Sample: 12 Golden Living Center-Fountainview Place was found to be in Compliance with 42 CFR part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the PSR to the Investigation of Complaint IN00179466. Quality review completed by 26143, on December 14, 2015.	{F 000}		