STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN0027955. Complaint IN00297955 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F725. Survey dates: June 15, 16 and 17, 2019 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 109 Total: 109 Census Payor Type: Medicare: 8 Medicaid: 95 Other: 6 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on June 20, 2019.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		7/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 689	Continued From page 1	F 689		

accidents.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to ensure cognitively impaired residents were provided with adequate supervision to prevent falls for 2 of 3 residents reviewed for falls (Resident C and Resident D).

Findings include:

1. The clinical record for Resident C was reviewed on 6/16/2019 at 10:56 AM . Diagnoses included, but were not limited to, dementia, depressive episodes, macular degeneration, hypertension, diabetes type 2 and pain.

The most recent Significant change Minimum Data Set (MDS) assessment, dated 5/13/2019, indicated the resident was severely cognitively impaired, required extensive the assistance of one staff member for walking, locomotion eating and personal hygiene and extensive assistance of two staff members for bed mobility, transfers and toilet use.

A fall risk assessment, dated 3/19/2019, indicated the resident was at risk for falls with a score of 18. Scores of 10 or above deemed the resident at risk for falls.

A progress note, dated 5/14/2019 at 8:47 PM, indicated the resident was found on the floor in the dining room while waiting for trays to be served. Interventions included, but were not limited to, staff educated on dining room supervision.

A progress note, dated 5/20/2019 at 5:49 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 689	Continued From page 2	F 689		

indicated the resident was witnessed sliding from her wheelchair onto the floor while in the dining room.

A progress note, dated 5/25/2019 at 5:16 PM, indicated the resident was found on the floor in the hallway with the wheelchair on top of her. Interventions included the placement of anti tippers to wheelchair.

The resident had a care plan for falls dated 9/18/2014. The interventions included, but were not limited to, educating staff on dining room supervision.

2. The clinical record for Resident D was reviewed on 6/16/2019 at 12:59 PM. Diagnoses included, but were not limited to, Alzheimer's, mood disorder, hypertension, venous insufficiency and hypothyroidism.

The most recent Quarterly Minimum Data Set (MDS) assessment, dated 5/19/2019, indicated the resident was severely cognitively impaired and required the extensive assistance of one staff member for bed mobility, transfers, walking locomotion and toilet use.

The fall risk assessment, dated 5/19/2019, indicated the resident was at risk for falls with a score of 16. Scores of 10 or above deemed the resident at risk for falls.

The progress note, dated 5/15/2019 at 1:24 PM, indicated the resident fell on 5/15/2019 at 11:44 AM. The resident was found on the floor in front of her wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 689	Continued From page 3	F 689		

The progress note, dated 5/29/2019 at 11:32 AM, indicated the resident was found on the floor after sliding out of her wheelchair.

The resident had a care plan for falls dated 4/1/2016. The interventions included, but were not limited to, dycem placed in wheelchair and white noise in hallway as resident tolerates.

Review of a resident fall list provided by the DON (Director of Nursing) on 6/15/2019 at 5:23 PM, indicated from 4/11/2019 though 6/5/2019 the two memory care units documented 13 unwitnessed resident falls.

During an interview on 6/15/2019 at 2:14 PM, a resident family member indicated the current staffing on the locked memory care units was not the normal staffing. The family member indicated the current staffing was "much better" than usual stating that most evenings there was only one aide on each unit.

Anonymous staff interviews were completed throughout the survey:

During an interview, Employee 2 indicated there was not enough staff to provide adequate supervision to prevent falls for the cognitively impaired residents on the locked memory care units. There was often only one nurse and one CNA (Certified Nursing assistant). "There just isn't enough of us to watch everyone like we should."

During an interview, Employee 4 indicated "There is not enough staff to watch the residents the right way."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 689	Continued From page 4 During an interview, Employee 5 indicated "It isn't safe to have only 1 CNA because of the type of residents we have." During an interview, Employee 6 indicated "Staffing is not good. There isn't adequate staff to make sure the residents are safe. It's a difficult resident population. It is very stressful." During an interview, Employee 9 indicated "We don't have enough staff and these residents are different. They need a lot of care. We don't have staff to watch the residents, that is why the falls are unwitnessed." During an interview, Employee 10 indicated "We have more unwitnessed falls because there is not enough staff." This Federal tag relates to Complaint IN00297955.	F 689		
F 725 SS=D	3.1-45(a)(2) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 725	Continued From page 5	F 725		

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews the facility failed to provide adequate staffing for 1 of 5 residents (Resident D) observed during a meal out of 54 cognitively impaired residents who live on the memory care units.

Findings included:

During a meal observation on 6/15/2019 at 5:20 PM, 15 residents were observed in the dining room of the step up memory care unit. The room was crowded with 10 residents in wheelchairs and limited space to maneuver between tables. One staff member was observed passing trays, one staff member was observed bringing residents into the dining room and seating them. At 5:20 PM, Resident D's pureed meal was placed in front of her. Resident D required extensive assistance of one staff member with meals. The resident made no attempt to reach for the food or feed herself. At 5:56 PM, two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 725	Continued From page 6	F 725		

more staff members arrived to assist in the dining room and a staff member sat down to assist the resident with her meal, 36 minutes after her tray was placed in front of her.

The clinical record for Resident D was reviewed on 6/16/2019 at 12:59 PM. Diagnoses included, but were not limited to, Alzheimer's, mood disorder, hypertension, venous insufficiency and hypothyroidism.

The most recent Quarterly Minimum Data Set (MDS) assessment, dated 5/19/2019, indicated the resident was severely cognitively impaired and required extensive assistance of one staff member for bed mobility, transfers, walking, locomotion and toilet use.

Review of the actual worked staffing for the past 2 weeks indicated the following:
6/1/2019 day shift 3.5 CNAs from 6AM-2PM for 54 residents
6/2/2019 day shift 3.5 CNAs from 6AM- 2PM and evening shift 3.5 CNA from 2PM-10PM for 54 residents
6/3/2019 evening shift 2 CNAs from 6PM-10PM for 54 residents
6/4/2019 evening shift 3 CNAs from 6PM-10PM for 54 residents
6/5/2019 evening shift 3 CNAs from 6PM-10PM for 54 residents
6/10/2019 night shift 1 CNA from 10PM-2AM for 54 residents

During an interview on 6/17/2019 at 10:42 AM, LPN 13 indicated staffing is "not good". LPN 13 indicated she tried to staff 5 CNAs on the day shift, 4 CNAs on evening shift and 2 CNAs on the night shift for the memory care units.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 725	Continued From page 7	F 725		

During an interview on 6/15/2019 at 2:14 PM, a memory care resident family member indicated the current staffing on the locked memory care units was not the normal staffing. The family member indicated the current staffing was "much better" than usual stating that most evenings there is only one aide on each unit.

Anonymous staff interviews were conducted throughout the survey.

During an interview, Employee 2 indicated there was not enough staff to provide adequate supervision for the cognitively impaired residents on the locked memory care units. Indicated there is often only one nurse and one CNA (Certified Nursing assistant). "There just isn't enough of us to watch everyone like we should."

During an interview, Employee 4 indicated "There is not enough staff to watch the residents the right way."

During an interview, Employee 5 indicated "It isn't safe to have only 1 CNA because of the type of residents we have."

During an interview, Employee 6 indicated there "Staffing is not good. There isn't adequate staff to make sure the residents are safe. It's a difficult resident population. It is very stressful."

During an interview, Employee 9 indicated there was not enough staff to provide adequate supervision. "We are short staffed so we are trying to get people in PJs (pajamas) around 3:00 PM-4:00 PM to help second shift. It is not good. We do not normally have this much help in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	C 06/17/2019

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 725	Continued From page 8 dining room and the residents are not helped with their meals like they should be. We just can't do it all." This Federal tag relates to Complaint IN00297955. 3.1-17(a)	F 725		