

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2015
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NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00178125.</p> <p>Complaint IN00178125 - Substantiated. Federal/State deficiencies related to the allegations are cited at F224 and F314.</p> <p>Survey dates: August 3, 2015</p> <p>Facility Number: 000681 Provider Number: 155549 AIM Number: 100286100</p> <p>Census Bed Type: SNF: 6 NF: 33 Residential: 5 Total: 44</p> <p>Census Payor Type: Medicare: 6 Medicaid: 33 Other: 5 Total: 44</p> <p>Sample: 4</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0224 SS=D Bldg. 00	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review, and interview, the facility failed to ensure the nursing staff followed facility policy and procedure to protect residents from incidents of neglect for 1 of 4 residents reviewed for neglect. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 8/3/15 at 10:00 a.m. The clinical record indicated the resident was admitted to the facility on 4/17/15. Resident B's current diagnoses included, but were not limited to, delirium, hydrocephalus, dementia, Alzheimer's disease, depression and hypertension. Resident B had an order for comfort care</p>	F 0224	Resident B is no longer at the facility. The facility followed their abuse policy, in that, an investigation was immediately initiated and the incident was reported immediately to ISDH, the MD, and the POA of the resident. A thorough investigation was completed by the facility and the employee was terminated. All residents have the potential to be affected. See below for corrective actions. The facility's policies for abuse and skin management were reviewed and no changes are indicated at this time. The nursing staff have been re-educated on the skin management program with a special focus on turning and repositioning residents every two hours. (See Attachment A). Staff was also re-educated on the	08/14/2015

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	<p>only dated 7/20/15.</p> <p>Review of the clinical record indicated that on 7/16/15 Resident B was found to have edema and water filled blisters on the left hand and fingers and a persistent red area on the left hip. The facility started an investigation as to the probable cause of the injuries at that time. The investigation indicated CNA #1 had checked the resident at 2:00 a.m. and attempted to reposition Resident B twice. CNA #1 indicated Resident B stated "no no", and CNA #1 left Resident B positioned on the left side. The CNA indicated she did not check Resident B at 4:00 a.m. The facility also questioned the nurse on duty, RN #2, with CNA #1 and RN #2 indicated she was unaware CNA #1 had any problems with Resident B. RN #2 indicated to the facility CNA #1 would request assistance if it were required to turn, reposition or change residents.</p> <p>Review of the "Pressure Ulcer Assessment" sheets indicated the following: On 7/16/15 a stage 2 fluid filled pressure area, located on the left hand 4th digit, measured 5 cm x 1.5 cm x 1.5 cm. On 7/24/15 the wound remained fluid filled and measured 5 cm x 1.5 cm x 1.5 cm.</p>		<p>abuse policy with a special focus on neglect (See Attachment B). A Skin Management Observation form has been initiated (See Attachment C). The DON/Designee will be responsible for completing the Skin Management Observation form to ensure preventative skin care, including turning and repositioning at least every 2 hours, is being completed. These observations will occur on scheduled work days as follows: daily for two weeks then weekly thereafter on an ongoing basis for a minimum of 6 months. Should a concern be found, immediate corrective action will occur. Results of these observations and any corrective actions will be reviewed during the facility's quarterly QA meetings and the plan adjusted accordingly if indicated.</p>		

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	<p>On 7/31/15 the wound was dark red, dry, and measured 5 cm x 1.5 cm x <.1 cm.</p> <p>On 7/16/15 a stage 2 fluid filled pressure area, located on the left wrist, measured 6 cm x 1.5 cm x .5 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 6 cm x 1.5 cm x .5 cm.</p> <p>On 7/31/15 the wound was dark red, dry, and measured 6 cm x 1.5 cm x <.1 cm.</p> <p>On 7/16/15 a stage 2 fluid filled pressure area, located on the left hand 2nd digit, measured 7.5 cm x 1.5 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 7.5 cm x 1 cm x 1.5 cm.</p> <p>On 7/31/15 the wound was dark red, dry, and measured 7.5 cm x 1 cm x <.1 cm.</p> <p>On 7/16/15 a stage 2 fluid filled pressure area, .located on the left hand 3rd digit, measured 3.5 cm x 1 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 3.5 cm x 1 cm x 1 x cm.</p> <p>On 7/31/15 the wound was dark red, dry, and measured 3.5 cm x 1 cm x <.1 cm.</p> <p>On 7/16/15 a second stage 2 fluid filled pressure area, located on the left hand 3rd digit, measured 7.5 cm x 2 cm x 1 cm.</p> <p>On 7/24/15 the wound remained fluid</p>			

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	<p>filled and measured 5.7 cm x 2 cm x 1 cm.</p> <p>On 7/31/15 the wound was dark red, dry, and measured 7.5 cm x 2 cm x <.1 cm.</p> <p>On 7/16/15 a stage 2 fluid filled pressure area, located on the left hand 5th digit, measured 5 cm x 2 cm x .5 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 5 cm x 2 cm x .5 cm.</p> <p>On 7/31/15 the wound was dark red and measured 5 cm x 2 cm x <.1 cm.</p> <p>On 7/16/15 a stage 2 fluid filled pressure area, located on the left hand, measured 2.5 cm x 5 cm x .5 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 2.5 cm x 5 cm x .5 cm.</p> <p>On 7/31/15 the wound was dark red and measured 2.5 cm x 5 cm x <.1 cm.</p> <p>Review of a current care plan dated 7/7/15 titled "Pressure Ulcer:, indicated interventions that included but were not limited to, "Assist/encourage to turn and reposition at least every two hours and as needed.</p> <p>During an interview on 8/3/15 at 1:00 p.m., CNA #3 indicated Resident B had been left on her left side and in a bed soaked with urine for an extended period of time which caused the skin</p>			

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	<p>breakdown.</p> <p>During an interview on 8/3/15 at 1:14 p.m., RN #4 indicated resident B had been rapidly declining over the past week. RN #4 indicated family had chosen to make her comfort care only.</p> <p>During an observation on 8/3/15 at 1:17 p.m., of incontinence care, Resident B was observed to be unresponsive to verbal or tactile stimuli. Resident B did not moan or speak during the care. The nursing staff providing the care, stripped Resident B's bed and changed the sheets that were wet with urine. CNA #3 indicated Resident B did not void often and needed to be checked on often. "I check on her at least every hour and reposition her. I check to make sure she isn't; wet. CNA #3 indicated Resident B did not have urinary output frequently, but when Resident B did have urinary incontinence, it was not uncommon for her to soak the bed.</p> <p>During an observation on 8.3/15 at 1:17 p.m., Resident B was noted to have several dark red areas on her left hand and fingers. The areas appeared to be healing and were dry and no longer fluid filled blisters.</p> <p>A current policy dated 10/2914 titled</p>			

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	<p>"Abuse Prohibition, Reporting and Investigation" indicted the following: " Policy: It is the policy of this facility allegations of abuse will be communicated to, and thoroughly investigated by, the correct authority. ...4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, anguish or deprivation of an individual of goods ore services that are necessary to attain or maintain physical, mental or psychosocial well-being. ... Neglect - Failure to provide goods and services necessary to avoid physical harm, mental and /or physical anguish or mental illness. Staff to resident. Other (visitor or relative) to resident. ... 15. Supervisory personnel shall be responsible to monitor areas of the facility. environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility. 16. Supervisory personnel shall be responsible to monitor deployment of personnel on each shift in sufficient numbers to meet the needs of the residents, and to identify inappropriate behaviors which may lead to conflict or neglect. ..."</p> <p>Review of the investigative report</p>						

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F 0314 SS=D Bldg. 00	<p>indicated CNA #1's employment was terminated due to the investigative findings of the CNA neglecting to reposition the resident to prevent skin breakdown.</p> <p>This federal tag relates to Complaint IN00178125.</p> <p>3.1-28(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>			

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	<p>Based on record review, and interview, the facility failed to ensure the nursing staff followed facility policy and procedure to protect residents from incidents of neglect resulting in the development of skin breakdown for 1 of 4 residents reviewed for neglect. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 8/3/15 at 10:00 a.m. The clinical record indicated the resident was admitted to the facility on 4/17/15. Resident B's current diagnoses included, but were not limited to, delirium, hydrocephalus, dementia, Alzheimer's disease, depression and hypertension. Resident B had an order for comfort care only dated 7/20/15.</p> <p>Review of the clinical record indicated that on 7/16/15 Resident B was found to have edema and water filled blisters on the left hand and fingers and a persistent red area on the left hip. The facility started an investigation as to the probable cause of the injuries at that time. The investigation indicated CNA #1 had checked the resident at 2:00 a.m. and attempted to reposition Resident B twice. CNA #1 indicated Resident B stated "no no", and CNA #1 left Resident B</p>	F 0314	<p>Resident B is no longer at the facility. The facility followed their abuse policy, in that, an investigation was immediately initiated and the incident was reported immediately to ISDH, the MD, and the POA of the resident. A thorough investigation was completed by the facility and the employee was terminated. All residents have the potential to be affected. See below for corrective actions. The facility's policies for abuse and skin management were reviewed and no changes are indicated at this time. The nursing staff have been re-educated on the skin management program with a special focus on turning and repositioning residents every two hours (See Attachment A). Staff was also re-educated on the abuse policy with a special focus on neglect (See Attachment B). A Skin Management Observation form has been initiated (See Attachment C). The DON/Designee will be responsible for completing the Skin Management Observation form to ensure preventative skin care, including turning and repositioning at least every 2 hours, is being completed. These observations will occur on scheduled work days as follows: daily for two weeks then weekly thereafter on an ongoing basis for a minimum of 6 months. Should a concern be found, immediate corrective action will occur.</p>	08/14/2015			

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	<p>positioned on the left side. The CNA indicated she did not check Resident B at 4:00 a.m. The facility also questioned the nurse on duty, RN #2, with CNA #1 and RN #2 indicated she was unaware CNA #1 had any problems with Resident B. RN #2 indicated to the facility CNA #1 would request assistance if it were required to turn, reposition or change residents. CNA #1 was terminated from employment as a result of this investigation.</p> <p>Review of the "Pressure Ulcer Assessment" sheets indicated the following: On 7/16/15 a stage 2 fluid filled pressure area, located on the left hand 4th digit, measured 5 cm x 1.5 cm x 1.5 cm. On 7/24/15 the wound remained fluid filled and measured 5 cm x 1.5 cm x 1.5 cm. On 7/31/15 the wound was dark red, dry, and measured 5 cm x 1.5 cm x <.1 cm.</p> <p>On 7/16/15 a stage 2 fluid filled pressure area, located on the left wrist, measured 6 cm x 1.5 cm x .5 cm. On 7/24/15 the wound remained fluid filled and measured 6 cm x 1.5 cm x .5 cm. On 7/31/15 the wound was dark red, dry and measured 6 cm x 1.5 cm x <.1 cm.</p>		Results of these observations and any corrective actions will be reviewed during the facility's quarterly QA meetings and the plan adjusted accordingly if indicated.				

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	<p>On 7/16/15 a stage 2 fluid filled pressure area, located on the left hand 2nd digit, measured 7.5 cm x 1.5 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 7.5 cm x 1 cm x 1.5 cm.</p> <p>On 7/31/15 the wound was dark red, dry, and measured 7.5 cm x 1 cm x <.1 cm.</p> <p>On 7/16/15 a stage 2 fluid filled pressure area, .located on the left hand 3rd digit, measured 3.5 cm x 1 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 3.5 cm x 1 cm x 1 x cm.</p> <p>On 7/31/15 the wound was dark red, dry, and measured 3.5 cm x 1 cm x <.1 cm.</p> <p>On 7/16/15 a second stage 2 fluid filled pressure area, located on the left hand 3rd digit, measured 7.5 cm x 2 cm x 1 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 5.7 cm x 2 cm x 1 cm.</p> <p>On 7/31/15 the wound was dark red, dry, and measured 7.5 cm x 2 cm x <.1 cm.</p> <p>On 7/16/15 a stage 2 fluid filled pressure area, located on the left hand 5th digit, measured 5 cm x 2 cm x .5 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 5 cm x 2 cm x .5 cm.</p> <p>On 7/31/15 the wound was dark red, dry, and measured 5 cm x 2 cm x <.1 cm.</p>			

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	<p>On 7/16/15 a stage 2 fluid filled pressure area, located on the left hand, measured 2.5 cm x 5 cm x .5 cm.</p> <p>On 7/24/15 the wound remained fluid filled and measured 2.5 cm x 5 cm x .5 cm.</p> <p>On 7/31/15 the wound was dark red and measured 2.5 cm x 5 cm x <.1 cm.</p> <p>During an interview on 8/3/15 at 1:00 p.m., CNA #3 indicated Resident B had been left on her left side and in a bed soaked with urine for an extended period of time which caused the skin breakdown.</p> <p>During an observation on 8.3/15 at 1:17 p.m., Resident B was noted to have several dark red areas on her left hand and fingers. The areas appeared to be healing and were dry and no longer fluid filled blisters.</p> <p>This federal tag relates to Complaint IN00178125.</p> <p>3.1-40(a)(1)</p>			