

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/27/2013
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
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F000000	<p>This visit was for the Investigation of Complaint IN00134594.</p> <p>Complaint IN00134594 Substantiated. Federal/State deficiency related to the allegations was cited at F312.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: August 26 and 27, 2013</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 104 Total: 104</p> <p>Census payor type: Medicare: 9 Medicaid: 81 Other: 14 Total: 104</p> <p>Sample: 8</p> <p>These deficiencies also reflect state</p>	F000000	<p>Disclaimer Statement: Submission of the plan of Correction is not admission that the deficiency exists or that they were cited correctly. This plan of correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal and State law. "This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements"</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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	findings cited in accordance with 410 IAC 16.2.  Quality review completed by Debora Barth, RN.				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who needed assistance with eating received assistance in a timely manner for 1 of 3 residents (Resident #D) reviewed for dining assistance and failed to ensure a resident who needed assistance with hair and nail care received assistance as needed for 1 of 3 residents (Resident #C) reviewed for hair and nail care in a sample of 8.</p> <p>Findings include:</p> <p>1.) During an observation of the supper meal in the main dining room on 8/26/13 from 6:13 p.m. through 6:36 p.m., the following was noted:</p> <p>6:13 p.m. - Resident #D was up in her reclining geri-type chair in the dining room. She was reclined back slightly. Her eyes were closed. Her evening meal was on the table in front of her. Her drinks were still covered with plastic. Her full meal was present.</p>	F000312	<p>1. Resident D was fed her evening meal by the Director of Nursing. Resident C had her hair combed and nails cleaned and trimmed. 1 to 1 education was provided to the CNA assigned to resident C. 2. All residents that need assistance with eating, hair combed, cleaning and trimming nails have the potential to be affected by this alleged practice. All residents will have their nails checked for needed nail care. 3. Nursing staff will be in-serviced regarding providing ADL care and feeding all residents sitting at the table at the same time. 4. Director of Nursing/Designee will do random audits of 5 residents per day 5 times per week at different times and on different shifts to ensure proper ADL care has been provided for 4 weeks then 5 residents per day 3 times a week for 8 weeks then 5 residents 1 time a week for 12 weeks. Any identified concerns will be corrected immediately and retraining/discipline provided as needed. Audits will be reported to QAPI monthly for 6 months.</p>	09/13/2013			

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	<p>6:14 p.m. - An unidentified staff member came and sat down and started feeding another resident sitting across the table from Resident #D. She did not offer assistance to Resident #D.</p> <p>On two occasions during the 23 minute time period, an unidentified staff member walked up to Resident #D's side of the table and offered her one bite of food and then returned to another resident. During this time period, no one sat down and attempted to feed the resident her meal.</p> <p>6:35 p.m. - Staff (now LPN #1) continued to feed the resident across the table from Resident #D. Resident #D remained in the same position as noted previously at 6:13 p.m. Her drinks were still uncovered. Only the two bites of food had been eaten.</p> <p>LPN #1 was interviewed on 6/26/13 at 6:35 p.m., and additional information was requested related to Resident #D not being assisted with her meal. LPN #1 indicated Resident #D was difficult to feed. She indicated some staff members could get the resident to eat better than others.</p> <p>The Administrator came into the dining room area on 6/26/13 at 6:35 p.m. The Administrator was interviewed at that</p>				

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	<p>time and concerns were expressed related to the lack of any feeding assistance having been offered to Resident #D. The Administrator indicated she would obtain assistance for the resident.</p> <p>During an observation on 8/26/13 at 6:45 p.m., the Assistant Director of Nursing (ADON) was now feeding the resident. She indicated she had warmed up the resident's food. The resident had eaten her pureed vegetable and pureed fruit. A half glass of thickened liquid had also been consumed.</p> <p>The clinical record for Resident #D was reviewed on 8/27/13 at 1:10 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, Alzheimer's disease, dementia, hypertension, vitamin deficiency, and depressive disorder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 8/8/13, indicated the resident had problems with both short and long term memory and was moderately cognitively impaired. The assessment indicated the resident was totally dependent on the staff for eating and received a mechanically altered diet.</p> <p>A health care plan problem, revised on 8/20/13, indicated the resident received a</p>				

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	<p>mechanically altered diet and liquids secondary to dysphagia. Approaches for this problem included, but were not limited to, pureed diet with nectar thick liquids and monitor intakes daily.</p> <p>The August, 2013 meal consumption records for Resident #D indicated she had consumed 50% of the evening meal on 8/26/13 after receiving assistance from the staff with eating.</p> <p>Review of the facility police, dated 2006, provided by the Administrator on 8/27/13 at 1:00 p.m., titled "Eating Support", included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>To assist the resident with feeding as necessary. To provide adequate nutrition.</p> <p>...Equipment</p> <p>Diet as ordered.</p> <p>Assistive devices as needed....</p> <p>Procedure</p> <p>1. Take tray to resident.</p>				

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	<p>...3. Place tray directly in front of resident.</p> <p>4. Assist resident to proper sitting position unless contraindicated.</p> <p>...7. Cut or divide food into small portions and give resident a small amount at a time....</p> <p>9. Never make the resident feel that the meal must be hurried, but that the procedure is pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident when possible...."</p> <p>2.) During an observation on 8/26/13 at 6:13 p.m., Resident #C was being wheeled out of the dining room by her daughter. The resident's hair was uncombed. The hair was flat in back and sticking out in an unkempt manner on both sides of her head. The resident's daughter expressed concerns over her mother's appearance and also indicated her nails were long and soiled.</p> <p>During an observation on 8/27/13 at 10:40 a.m., Resident #C was up in her wheelchair in the dining room with other residents. Her hair was unkempt. It was flat in back and sticking out to the sides. An unidentified CNA came and got the</p>						

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	<p>resident and wheeled her back to the hallway by her room.</p> <p>During an observation on 8/27/13 at 10:43 a.m., the resident was up in her wheelchair outside the door of her room. She held up her hands so her nails could be seen. Her fingernails were long and uneven. There was a dark substance noted under at least three of her fingernails.</p> <p>LPN #2 (the nurse passing medications near the resident's door) was interviewed on 8/27/13 at 10:45 a.m. related to the unkempt appearance of Resident #C's hair and nails. LPN #2 did not check the resident, but indicated she knew she was going to get a shower that morning.</p> <p>The clinical record for Resident #C was reviewed on 8/27/13 at 12:55 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, cerebral artery disease with infarct, altered mental status, anxiety disorder, and hypertension.</p> <p>A quarterly MDS assessment, dated 7/2/13, indicated the resident required extensive assistance of the staff for bathing and hygiene needs.</p> <p>A health care plan problem, revised on</p>			

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	<p>7/16/13, indicated Resident #C had a self care impairment. One of the approaches for this problem was "Personal Hygiene assistance."</p> <p>Review of the current facility policy, dated 2006, provided by the Administrator on 8/27/13 at 1 p.m., titled "Hair and Scalp Care", included, but was not limited to, the following:</p> <p>"Purpose</p> <p>...To provide the resident with an attractive appearance and improve morale....</p> <p>Equipment</p> <p>Comb and hair brush...</p> <p>Procedure...</p> <p>3. Resident's hair is to be combed during morning and evening care; more often if necessary.</p> <p>...8. Comb resident's hair in the desired style...."</p> <p>This federal tag relates to Complaint IN00134594.</p> <p>3.1-38(a)(3)(B)</p>						

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	3.1-38(a)(3)(E)				

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure residents residing on the secure dementia unit were not left unattended by staff for 14 of 19 residents living on the unit observed for supervision to prevent accidents and/or injury. ( Residents # M, N, O, P, Q, R, S, T, U, V, W, X, Y, and Z)</p> <p>Findings include:</p> <p>The Administrator was interviewed on 8/26/13 at 6 p.m. She indicated all of the residents living on the locked dementia unit, referred to as the "Step-up" unit, had some sort of dementia diagnoses and none were interviewable.</p> <p>During an observation on 8/27/13 from approximately 11:17 through 11:20 a.m., no staff were observed on the locked dementia unit referred to as the "Step-up" unit.</p> <p>Two residents were observed up in chairs unattended in the dining room</p>	F000323	<p>1. Certified Nursing Assistants assigned to the "Step up Unit" were immediately back on the Unit. Executive Director provided education to both CNA's about leaving the Unit unattended on 8-27-13. 2. All residents that require supervision have the potential to be affected by this alleged practice. 3. Nursing staff will be in-serviced on not leaving their units unattended. Certified Nursing Assistants will also be in-serviced on not leaving their unit without notifying the licensed nurse first. 4. Director of Nursing/Designee will make random rounds verifying staff is present on assigned units 3 times a day 5 days a week on-going. Negative outcomes will be corrected immediately. Education or discipline will also be provided as needed. Negative outcomes will be reported to QAPI monthly for 6 months.</p>	09/13/2013			

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	<p>area. At least two different residents were observed ambulating in the hall and dining room of the unit. Two residents were up in chairs in a lounge area at the end of the unit. A window in this lounge was present that viewed a courtyard area outside the unit.</p> <p>On 8/27/13 at 11:19 a.m., staff and several residents were observed outside of the building in the courtyard area viewed from this window.</p> <p>On 8/27/13 at 11:20 a.m., two CNAs entered the unit through the back outside entrance. The two CNAs were interviewed at that time. CNA #3 and CNA #4 identified themselves as the two CNAs working that day on the Step-up unit. When asked where the nurse was who worked the unit with them that day, they indicated she was in her office (which is behind a closed door at the opposite end of the unit). When queried if the nurse knew both of the CNAs were out of the building at the same time and the unit was unattended, they indicated "No". They indicated they had just gone out for a few minutes to check on the activity staff person who was outside with six of the residents.</p>				

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	<p>During an observation on 8/27/13 at 11:27 a.m., LPN #5 was now observed in the hallway by the nursing station and was bringing the medication cart down the hall.</p> <p>LPN #5 was interviewed on 8/27/13 at 11:28 a.m. LPN #5 indicated she was the nurse working on the Step-up unit with CNA #3 and CNA #4 that day. She indicated she did not know both CNAs had left the unit while she was in the nursing office. She indicated both CNAs should not have gone outside without notifying her they would be off the unit.</p> <p>The Activity Assistant was interviewed on 8/27/13 at 2:15 p.m. She indicated 6 residents had been outside with her at the gardening activity in the courtyard that morning. One of the residents was from the Mid Unit and 5 residents were from the Step-up unit. She indicated CNA #4 had came outside first that morning and was only out there approximately 4 minutes. She indicated CNA #3 then came out and was only out a very short time before both CNAs returned to the unit. She indicated she also had a family volunteer outside with her to help with the residents.</p>				

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	<p>Review of the Step up unit roster, provided by LPN #5 on 8/27/13 at 2:05 p.m., indicated 19 residents lived on the unit. This indicated 14 residents on the unit were left unattended and unsupervised when CNA #3 and CNA #4 were both outside of the building with the activity staff and the 5 other residents who resided on the unit. The residents included: Resident M, N, O, P, Q, R, S, T, U, V, W, X, Y, and Z.</p> <p>Behavior logs, used to monitor resident behaviors on the Step-up unit, provided by the Unit Manager on 8/27/13 at 2:00 p.m., were reviewed at that time. The logs lacked any information related to abusive and/or argumentative behaviors exhibited by residents during the month of August from 8/1/13 through 8/27/13 at 2 p.m.</p> <p>3.1-45(a)(2)</p>			