

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  11/27/2012
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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 IN00118874.</p> <p>Complaint number IN00118874 substantiated, federal deficiencies related to the allegations are cited at f 323.</p> <p>Survey dates: November 26 and 27, 2012</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Survey Team: Julie Call, RN, TC Virginia Terveer, RN</p> <p>Census bed type: SNF/NF: 105 Total: 105</p> <p>Census payor type: Medicare: 16 Medicaid: 84 Other: 5 Total: 105</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2013  
FORM APPROVED  
OMB NO. 0938-0391

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	Quality review completed 11/29/12 Cathy Emswiller RN				

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F000323 SS=D	<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, interview and record review, the facility failed to provide adequate supervision of a wheelchair bound, cognitively impaired resident at risk for and with a history of falls, who fell out of a wheelchair and sustained injuries for 1 of 3 residents reviewed for falls with injury. (Resident #E)</p> <p>Findings include:</p> <p>Resident #E's record review began on 11-27-2012 at 11:14 a.m.</p> <p>Resident #E's diagnoses included but were not limited to: anemia (low blood hemoglobin), anxiety, atrial fibrillation (irregular heartbeat), cerebellar ataxia (disturbance in muscle coordination), cerebral vascular disease (disease of blood vessels in the brain), congestive heart failure, dementia, generalized osteoarthritis (arthritis), loss of weight, osteoporosis (loss of bone mass), macular degeneration (decreased vision) and psychosis.</p>	F000323	Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. All corrections were made by 12-7-12It is the practice of the facility to ensure that the resident environment remains as free of accident hazards as is possible. I. Resident E no longer resides in the facility.II. All residents with Fall Risk scores of 10 or above have had their Fall Care Plans reviewed to ensure current interventions are implemented and remain appropriate.III. Each resident fall will be reviewed daily during clinical start-up with new interventions care planned and C.N.A assignment sheets updated at that time. Staff will have a documented in service on new interventions as written in care plan.IV. A QA tool titled " Fall Tracking Report" will be	12/07/2012			

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	<p>On 9-26-2012 at 10:10 a.m., a nurse aide assignment sheet provided by the nurse unit manager, #4, indicated Resident #E transferred with a wheelchair and a lift, was a fall risk and had personal alarms.</p> <p>Resident #E had a current significant change MDS (Minimum Data Set, a comprehensive clinical assessment) dated 11-13-2012, which indicated the Resident had 2 falls with injury defined as "(except major injury) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain." The MDS indicated Resident #E required total dependence for transfers, locomotion on and off unit with use of a wheelchair, dressing, toileting and personal hygiene and extensive assistance for eating. The significant change MDS and the quarterly MDS dated 10-21-2012 indicated Resident #E's cognitive skills were moderately impaired which indicated "decisions poor; cues/supervision required."</p> <p>A review of the nursing notes indicated Resident #E fell on the following dates: 9-6-2012 and 10-9-2012. Additional review of the resident's record revealed a Neurological/Vital Sign Check document with Resident #E's name and date of a</p>		utilized weekly to ensure all falls are compliance with updated care plan interventions and staff education. DNS will be responsible for reporting findings to the QA Committee on a monthly basis. V. Date of compliance 12/07/12.				

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	<p>fall, 11-20-2012.</p> <p>An interview with the Nurse #5 on 11-27-2012 at 2:30 p.m., indicated Resident #E fell out of the wheelchair on 11-20-2012 and an investigative report was being prepared.</p> <p>Review of the falls investigation reports for Resident #E indicated the following:</p> <p>a.) On 9-6-2012 at 8:50 a.m., Resident #E was in the dining room, propelled self, and leaned out of wheelchair and fell to the floor. Staff was unable to reach resident prior to fall. Resident #E sustained a bruise to the right forehead measuring 3.5 cm x 1 cm (centimeter=unit of measurement). The Fall Risk Assessment was updated on 9-18-2012 with a score of 18 (a score of 10 or above deems the resident is at risk). The CNA Post-Fall Report completed on 9-6-2012 indicated actions to help prevent future falls by CNA #6 "make sure resident is securely in chair and always try to keep a very close eye on resident."</p> <p>b.) On 10-9-2012 at 10:05 a.m., Resident #E was in the activity room and propelled himself around the love seat, became entangled and fell forward out of wheelchair to the floor. Resident #E sustained a bruise to the forehead (2.5 cm</p>						

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	<p>x 3 cm), a discoloration above nose and below center of forehead (2 cm x 0.5 cm) and a laceration (cut) on the bridge of the nose ( 0.2 cm x 0.1 cm). The Fall Risk Assessment was updated on 10-9-2012 with a score of 22. The care plan was updated but was not limited to the following: "staff to be within arms distance during activities."</p> <p>c.) On 11-20-2012 at 5:50 p.m., Resident #E was in the dining room in wheelchair and leaned forward and fell out of wheelchair to the floor. Resident #E sustained a hematoma (bruise) to the left forehead measuring 5.4 cm x 5.7 cm, left cheek swelling, and a left hand skin tear "V" shape to the knuckle measuring 1.7 cm x 1.4 cm and a skin tear to the right hand (no measurement). Resident #E was transferred to the emergency room for an x-ray, evaluation and treatment.</p> <p>The emergency department physician notes dated 11-20-2012 at 7:38 p.m., indicated but was not limited to the following: "unwitnessed fall from a nursing home; has hematoma to head and skin tears to bilateral hands; pt (patient) cannot provide any history." The CT scan (computed tomography-medical imaging procedure) done on 11-20-2012 at 8:23 p.m., indicated a "moderate left frontal scalp hematoma." Resident #E was</p>			

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	<p>discharged from the emergency room on 11-20-2012 at 9:07 p.m.</p> <p>A statement in the fall investigation report by CNA #7 on 11-20-2012 at 5:50 p.m., indicated "just walked away from resident to assist another. Unable to stop fall." The CNA Post-Fall Report completed on 11-23-2012 indicated actions to help prevent future falls by CNA #7 were to "keep closer to staff during meals" and by CNA #8 "up to table and near staff."</p> <p>On 11-27-2012 at 12:00 p.m., Resident #E was observed being propelled by the hospice nurse #9 to the dining room. The resident had a large bruise on the left side of the forehead. The resident did not respond verbally when approached.</p> <p>On 11-27-2012 at 2:20 p.m., Resident #E was observed in bed with bed in low position, mat cushion leaning on bedside table, call light in reach, bed alarm attached to bed and a low air loss mattress with bolsters.</p> <p>An interview with LPN #10 on 11-27-2012 at 2:20 p.m., indicated Resident #E was a fall risk and had to be watched closely.</p> <p>On 11-27-2012 at 5:15 p.m., Resident #E</p>						

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	<p>was observed being wheeled by CNA #11 to the dining room and positioned at a table with 2 other residents in wheelchair. CNA #11 was observed leaving the dining room. No staff were observed within arms distance of Resident #E.</p> <p>An interview with CNA #11 on 11-27-2012 at 5:15 p.m., indicated the new geri chair delivered earlier for Resident #E would be implemented tomorrow on 1st shift.</p> <p>An interview with the DON on 11-27-2012 at 5:35 p.m., indicated the intervention of staff being within arms distance of Resident #E was meant for scheduled activities only.</p> <p>An interview with the Administrator, DON and ADON during the exit conference on 11-27-2012 at 6:08 p.m., indicated they had no additional information regarding Resident #E's clinical record or Falls Investigation Reports.</p> <p>The facility "Falls Management Clinical Guidelines" revised January 2011 and provided by the DON on 11-27-2012 at 9:30 a.m., indicated following a resident's fall "appropriate interventions are implemented." Monitoring compliance included but was not limited to:</p>						

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	<p>"communication system to identify the residents risk for falls and care planned with individualized interventions" were not followed as evidenced by Resident #E not supervised in the dining room on 11-20-2012 as CNA #7 left to assist another CNA serve drinks and Resident #E fell from wheelchair.</p> <p>This federal tag relates to complaint IN00118874.</p> <p>3.1-45(a)(2)</p>				