

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaints IN00160704 and IN00162118.</p> <p>Complaint IN00160704 Substantiated. Federal/State deficiencies related to the allegations are cited at F328, and F371.</p> <p>Complaint IN00162118 Substantiated. Federal/State deficiencies related to the allegations are cited at F328.</p> <p>Survey dates: January 6 and 7, 2015</p> <p>Facility number: 000134 Provider number: 155229 AIM number: 100275430</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census payor type: Medicare: 12 Medicaid: 58 Other: 5 Total: 75</p> <p>Sample: 5</p>	F000000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation and request a desk review (paper compliance) of certification of compliance on or after February 6, 2015</p>	
---------	--	---------	---	--

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:  155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2015
NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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	
F000328 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure respiratory care equipment was stored in a manner to prevent possible contamination from viral and/or bacterial pathogens for 2 of 3 residents reviewed who received respiratory care services in a sample of 5. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B</p>	F000328	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 1. Resident B continues to use his CPAP at night per physician's orders. The mask is cleaned and stored in a plastic bag every morning after use. The CPAP machine, tubing and mask are then stored in his bedside table. 2. Resident C's O2 machine was cleaned thoroughly. All respiratory equipment, including	02/06/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2015
NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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	
	<p>was reviewed on 1/6/15 at 4:55 p.m. Diagnoses for the resident included, but were not limited to, end stage renal disease, transitional cell cancer of right ureter, obstructive sleep apnea, and chronic obstructive pulmonary disease.</p> <p>The resident had a current physician's order, dated 12/23/14, for the use of a C-PAP (continuous positive airway pressure) machine at night due to his diagnosis of obstructive sleep apnea.</p> <p>During an observation conducted with LPN #1 on 1/6/15 at 2 p.m., Resident #B was resting in his bed. His C-PAP machine with the mask and tubing attached were observed on the nightstand next to the bed. The C-PAP mask was uncovered and open to the air. Two urinals were also sitting on top of the bedside table near the C-PAP machine, tubing, and mask.</p> <p>LPN #1 was interviewed on 1/6/14 at 2 p.m. She indicated the respiratory equipment should not be stored in this manner and it would be corrected.</p> <p>2. The clinical record for Resident #C was reviewed on 1/7/15 at 1:25 p.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic respiratory failure with tracheostomy.</p>		<p>tubing, will be stored and cleaned according to policy and procedure. The tubing will be put in a plastic bag. The suction machine is being properly stored. Resident C is currently located in another facility due to the sprinkler leak we had on 1/12/15.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: 1. Any resident receiving oxygen or respiratory treatments could be affected. All supplies will be cleaned and bagged and stored according to policy and procedure. All nursing personnel were re-educated regarding this procedure on 1-8-15 and 1-9-15. 2. Any resident receiving oxygen or respiratory treatments could be affected. All supplies will be cleaned and bagged and stored according to policy and procedure. All nursing personnel were re-educated regarding this procedure on 1-8-15 and 1-9-15. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: 1. Nursing personnel were re-educated on 1-8-15 and 1-9-15 regarding the proper cleaning, bagging and storage of respiratory equipment. An audit tool will be used to monitor compliance. The audit</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2015
NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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	
	<p>A recapitulation of physician's orders, dated 12/31/14, included, but was not limited to, the following respiratory related orders:</p> <p>Oxygen at 2 liters per minute throughout the day (via tracheostomy mask) Oxygen at 4 liters per minute at night daily May suction trach PRN (as needed) Albuterol sulfate 2.5 milligrams/3 milliliters solution per nebulizer treatment every 8 hours as needed for wheezing</p> <p>A Nurse Practitioner (NP) note, dated 12/31/14, indicated the resident had been seen due to coughing up yellow phlegm in large amounts and the resident's complaints of not feeling well. The "Diagnosis and Plans" section of the note indicated the resident had "Acute bronchitis" but also possible "flu". The note indicated the NP would start the resident on Tamiflu (a medication given to help reduce flu symptoms) and Augmentin (an antibiotic) for bacterial infection. These orders were written by the NP on 12/31/14.</p> <p>During an observation conducted with LPN #1 on 1/6/15 at 3 p.m., Resident #C was lying in bed with her oxygen therapy</p>		<p>tool will be utilized 2 X's daily until 100% compliance has been met for 30 days. 2. Nursing personnel were re-educated on 1-8-15 and 1-9-15 regarding the proper cleaning, bagging and storage of respiratory equipment. An audit tool will be used to monitor compliance. The audit tool will be utilized 2 X's daily until 100% compliance has been met for 30 days. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: 1. The audit tool will be utilized 2 X's daily until 100% compliance has been met for 30 days. The results of this audit tool will be discussed during the monthly Performance Improvement (PI) meetings. After achieving 100% compliance for 30 days, the PI committee will determine whether to continue the audits or to monitor less frequently. 2. The audit tool will be utilized 2 X's daily until 100% compliance has been met for 30 days. The results of this audit tool will be discussed during the monthly Performance Improvement (PI) meetings. After achieving 100% compliance for 30 days, the PI committee will determine whether to continue the audits or to monitor less frequently. We respectfully request paper compliance for this tag.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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
	<p>in place via a tracheostomy mask. The resident's oxygen equipment was a two piece machine set up. The machine with the humidifier bottle attached had a mesh filter on the upper section that was heavily soiled with dust and debris. A nebulizer machine and nebulizer tubing were noted on the nightstand next to the bed. The nebulizer tubing and medication chamber on the tubing (used to administer the Albuterol treatment) were uncovered and open to the air. A suction machine was also present on the bedside stand. The suction catheter (used to suction secretions from the resident's trach) was attached to the suction container equipment. The suction catheter was uncovered and open to the air and tabletop of the bedside stand.</p> <p>LPN #1 was interviewed on 1/6/14 at 3 p.m. She indicated the filter on the oxygen machine should be cleaned and the respiratory equipment should not be stored in that manner and would be corrected. When leaving the resident's room, LPN #1 stopped an unidentified nurse in the hallway and gave instructions related to the equipment in the resident's room.</p> <p>3. Review of the current facility policy, dated August 2011, titled "Procedure for Cleaning Nebulizer Equipment",</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2015	
NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE				STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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			
	<p>provided by the Administrator 1/7/15 at 12:55 p.m., included, but was not limited to, the following:</p> <p>"...2. Cover nebulizer equipment when not it use.</p> <p>3. After each nebulizer treatment:</p> <p>...e. Store dry mouthpiece and medication cup in a dry plastic bag.</p> <p>Review of the current, undated facility policy, provided by the Administrator on 1/7/15 at 2:25 p.m., titled "Respiratory Care Services Policy and Procedure CPAP-Continuous Positive Airway Pressure", included, but was not limited to, the following:</p> <p>"...Procedure</p> <p>...15. Upon awakening, the patient should remove the mask and headgear.</p> <p>16. Properly clean the mask each morning or after each use by wiping with a disinfectant, and properly store..."</p> <p>Review of current facility policy, dated 5/1/12, provided by the Administrator on 1/7/15 at 12:55 p.m., titled "Suctioning and Care of Tracheostomies", included, but was not limited to, the following:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2015	
NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE				STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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			
F000371 SS=D	<p>"Purpose To ensure appropriate technique in care of tracheotomies.</p> <p>Policy ...3. Use sterile, disposable-suctioning catheters.</p> <p>...5. Use a sterile catheter each time the trachea is suctioned...."</p> <p>This federal tag relates to Complaint IN00160704 and IN00162118.</p> <p>3.1-47(a)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure a thermometer was maintained in resident room refrigerators to ensure the temperature was maintained at a safe level for food storage for 2 of 4 resident room refrigerators observed. (Resident #C and #F)</p> <p>Findings;</p>	F000371	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:A thermometer was placed in the refrigerator in rooms 57 and 60 for residents C & F on 1/7/15. An audit was completed on 1/8/15 of all rooms with refrigerators and a Refrigerator temperature log was placed on the side of all refrigerators for Housekeeping	02/06/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2015
NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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	
	<p>During an environmental tour, conducted with the Administrator on 1/7/15 at 1:55 p.m., the following was observed:</p> <p>Room 57- The refrigerator maintained for Resident #C contained various food items. The refrigerator appeared to be working and contained a small tray of ice. The refrigerator lacked any thermometer for the monitoring of the temperature of the refrigerator.</p> <p>Room 60- The refrigerator maintained for Resident #F contained yogurt and other food items. The refrigerator appeared to be working and contained a small tray of ice. The refrigerator lacked any thermometer for the monitoring of the temperature of the refrigerator.</p> <p>The Administrator was interviewed during the tour on 1/7/15 at 1:55 p.m. She indicated the above refrigerators should have a thermometer. She indicated an audit would be done of all resident refrigerators and thermometers would be obtained for all of them as needed.</p> <p>Review of the new facility policy, dated 1/7/15, provided by the Administrator on 1/7/15 at 1:50 p.m., titled "Refrigerator Storage", included, but was not limited</p>		<p>personnel to monitor daily. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN:All residents with a refrigerator could be affected. An audit was completed on 1/8/15 of all rooms with refrigerators and a Refrigerator temperature log was placed on the side of all refrigerators for Housekeeping personnel to monitor daily. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The housekeeping staff were educated regarding the added duty of checking each refrigerator daily during their daily cleaning schedule. They are checking for thermometers and cleanliness. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILLB E PUT INTO PLACE:An audit tool has been developed for use by the Housekeeping Supervisor to check 1 X weekly to assure the log is being properly completed. The results of the audit tool will be discussed during the monthly PI meetings. A determination of continuation will be made by the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2015
NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST 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	
	<p>to, the following:</p> <p>"Policy Refrigeration slows the growth of microorganisms and helps keep them from growing to levels high enough to cause illness. Refrigerated storage is used to hold potentially hazardous food at 41 degrees F or lower....</p> <p>Procedure 1. Proper Temperature. Set refrigerators to keep internal food temperature at 41 degrees F or lower. Place hanging thermometer in the warmest part of the refrigerator...."</p> <p>This federal tag relates to Complaint IN00160704.</p> <p>3.1-21(i)(3)</p>		<p>committee after it is reported that there has been 100% compliance for 30 days. We respectfully request paper compliance for this tag.</p>		