

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00176351 and IN00176971.</p> <p>Complaint IN00176351 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F9999.</p> <p>Complaint IN0076971 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F9999.</p> <p>Survey dates: July 6 and 7, 2015.</p> <p>Facility number: 000310 Provider number: 155443 AIM number: 100288970</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census payor type: Medicare: 7 Medicaid: 47 Other: 6 Total: 60</p> <p>Sample: 4</p> <p>These deficiencies also reflect state</p>	F 0000	000 Preparation and or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This POC is to serve as the Waters of Muncie's credible allegation of compliance. The Waters of Muncie requests paper compliance.	

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:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/07/2015
NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303		
(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 0323 SS=D Bldg. 00	<p>findings cited in accordance with 410 IAC 16.2-3.1.</p> <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 interview and record review, the facility failed to ensure a dependent resident was free from risk of injury of falls for 1 of 4 residents reviewed for fall risk. ( Resident B).</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 7/6/2015 at 9:43 a.m. Diagnoses for Resident B included, but were not limited to, hypertension, Alzheimer's Disease, dementia, delusional disorder, mood disorder, and major neuro cognitive disorder.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 4/30/2015, was reviewed on 7/6/2015 at 10:00 a.m. The MDS indicated Resident B was severely cognitively impaired. Resident B</p>	F 0323	F323 It is the policy of The Waters of Muncie to ensure that the resident environment remains as free of accidents as is possible. Resident B no longer resides in facility. All other dependent residents were assessed for injuries of unknown origin and no negative findings were found. To prevent a re-occurrence and ensure the safety of each resident,all resident reports of injury, will be reviewed at facility CQI meetings and the Interdisciplinary Team (IDT) will investigate each incident for root cause, and eliminate any environmental factors/causes as appropriate. The Director of Nursing/designee will be responsible for maintaining a record of any known resident injuries, and reporting all resident injuries to the Quality Assurance Committee. The Quality Assurance Committee will assume data collection and	08/06/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/07/2015	
NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303			
(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>received the following Activities of Daily Living (ADL) assistance; transfer-total assist with 2 person physical assist, dressing, bathing and hygiene- total assist with 2 person physical assist, eating-extensive assistance with two person assist and total assist with two person physical assist for toilet use. Resident B was assessed as always incontinent of bladder and bowel. Resident B had no impairments to range of motion in all extremities.</p> <p>Review of the incident report, dated 6/26/15, indicated Resident B was found in his room bleeding from two skin tears located on the left eyebrow region. The incident was unwitnessed and the injury was of an unknown origin.</p> <p>Review of the follow up report, dated 7/2/2015, indicated the following: "...Could resident have been injured by environmental factors? Resident resided in private room with private bathroom. Resident had electric bed with attached bed remote. Remote was located on left side of bed if resident was lying supine. Resident's call light was on left side of bed. Prior to resident's injury [staff member's name] observed that Resident B [Resident's name] possibly pulled call light, resulting in bedside lamp falling over on side...."</p>		oversight of facility compliance, monthly, ongoing, with ensuring all injuries are assessed for root cause and environmental changes are made as necessary to prevent further injury and ensure injuries of unknown origin are reported according to state regulations.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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>Review of care plans on 7/7/15 at 12:01 p.m. indicated Resident B had a care plan titled "Risk for falls due to history or recent falls". Interventions included, but were not limited to, "attempt to keep areas free of clutter and call light within reach." This care plan was dated 6/26/2014. It also indicated Resident B had a care plan titled "Potential for falls related to dementia". Interventions included, but were not limited to, "encourage to ask for assist with transfers or ambulation as needed." This care plan was dated 7/5/2014.</p> <p>Review of the Investigation Report by the Nurse Consultant and Clinical Director, on 7/6/2015 at 11:33 a.m. indicated "... the investigation was completed by the Administrator and concluded the injury was probably caused by a bed remote and the resident hitting self with the remote, or remote recoiling and hitting resident..."</p> <p>During an interview on 7/7/2015 at 9:06 a.m., LPN #1 indicated she was on duty at the time of the incident and did not know the cause of the injury.</p> <p>During an interview on 7/7/2015 at 1:36 p.m., the Administrator indicated after the investigation they were still unable to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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 9999  Bldg. 00	<p>determine the cause of the incident but felt it was due to an environmental factor.</p> <p>This federal tag relates to Complaints IN00176531 and IN00176871.</p> <p>3.1-45(a)(1)</p> <p>State Findings:</p> <p>"3.1-28 Staff treatment of residents</p> <p>(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency.</p> <p>This state rule was not met as evidenced by:</p>	F 9999	<p>F9999 It is the policy of the Waters of Muncie to report injuries of unknown origin, timely, and according to state regulations.</p> <p>Resident B no longer resides at facility. All residents were assessed for injuries of unknown origin and no other residents were found to be affected.</p> <p>On 6/26/2015 an in-service was held for all facility staff educating employees on the Elder Justice Act, Resident to Resident investigation guidelines, Injury of unknown origin guidelines, ISDH reporting guidelines including timeliness of reporting any incident, including injuries of unknown origin to Administrator and ISDH. The Administrator also received education on reportable guidelines, including</p>	08/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/07/2015
NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303		
(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>Based on record review and interview, the facility failed to ensure the Administrator reported, within (24) twenty-four hours, an injury of unknown origin to the Indiana State Department of Health (ISDH) in accordance with state regulation and facility policy. (Resident B).</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 7/6/2015 at 9:43 a.m. Diagnoses for Resident B included, but were not limited to, hypertension, Alzheimer's Disease, dementia, delusional disorder, mood disorder, and major neuro cognitive disorder. Resident B was admitted to the facility on 6/26/2014.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 4/30/2015, was reviewed on 7/6/2015 at 10:00 a.m. The MDS indicated Resident B was severely cognitively impaired. Resident B received the following Activities of Daily Living (ADL) assistance; transfer-total assist with 2 person physical assist, dressing bathing and hygiene- total assist with 2 person physical assist, eating-extensive assistance with two person assist and total assist with two person physical assist for toilet use. Resident B</p>		<p>timely reporting of injuries of unknown origin.</p> <p>To prevent a re-occurrence, any injuries of unknown origin will be reported immediately to the Administrator and ISDH and other agencies as appropriate. All resident injuries will be reviewed at facility CQI meetings and the IDT will review that injuries of unknown origin are investigated and reported timely and according to State regulations.</p> <p>The Director of Nursing/designee will be responsible for maintaining a record of any known resident injuries, and reporting all resident injuries to the Quality Assurance Committee. The Quality Assurance Committee will assume data collection and oversight of facility compliance, monthly, ongoing, with ensuring all injuries of unknown origin are reported timely and according to state regulation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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 always incontinent of bladder and bowel. Resident B had no impairments to range of motion in all extremities.</p> <p>Review of the nursing notes, provided by the Administrator, on 7/6/2015 at 10:30 a.m., indicated the following:</p> <p>On 6/13/2015 at 4:48 p.m., "Resident was lying in his bed when QMA noticed some blood on his face. She called this writer in and I observed some minimal bruising to the right (left) eyebrow region along with two small tears. Larger one measures 0.1 x 1 and second one 0.1 x 0.5." Signed by LPN #1.</p> <p>During an interview with the Administrator on 7/6/2015 at 8:43 a.m., information was requested related to the last ISDH reportables since the most recent annual survey. The incident was noted to have been reported on 6/26/15.</p> <p>Review of the incident report, dated 6/26/15, indicated Resident B was found in his room bleeding from two skin tears located on the left eyebrow region. The incident was unwitnessed and the injury was of an unknown origin.</p> <p>During an interview on 7/7/2015 at 9:06 a.m., LPN #1 indicated she called the Director of Nursing, the Administrator</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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>and the Assistant Director of Nursing. She also indicated she was unable to reach either of them, but that the Administrator returned her call and was informed of the incident.</p> <p>During an interview on 7/7/2015 at 1:36 p.m., the Administrator stated, "I was told the resident had a skin tear on his eye and eyelid. We didn't think it was a reportable, but upon further investigation we determined that it was a reportable and reported it at that time." The Administrator also stated, "We missed it and it should have been reported."</p> <p>During an interview on 7/6/2015 at 2:00 p.m., LPN #2 stated, "We are instructed in orientation to contact the Director of Nursing and the Administrator, regardless of day or time, if we suspect abuse or find an injury of unknown origin."</p> <p>During an interview on 7/6/2015 at 9:30 a.m., LPN #5 indicated upon finding an injury of unknown origin she would notify the Administrator, the Director of Nursing, the physician and the family of the resident. LPN #5 verbalized appropriate immediate actions for suspected abuse.</p> <p>Review of a policy dated 7/1/11, titled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/07/2015
NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303		
(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>"Abuse" indicated the following: "...Subject: Abuse-Reporting... Procedure: ...3. The Incident Documentation and Investigation Tool is to be submitted to the Administrator or designee as soon as possible within 24 hours for further investigation. The Administrator (or designee) will report Abuse/Neglect to the Department of Health within 24 hours per the Indiana Department of health reporting guidelines...."</p> <p>This Federal tag relates to Complaints IN00176531 and IN00176971.</p> <p>3.1-13(g)(1)</p>				