

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 06/04/2014
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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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F000000	<p>This visit was for the Investigation of Complaints IN00149768 and IN00149936.</p> <p>Complaint #IN00149768 - Substantiated. Federal/State deficiency related to the allegation is cited at F221.</p> <p>Complaint #IN00149936 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 3 and 4, 2014</p> <p>Facility number: 000681 Provider number: 155549 AIM number: 100286100</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF: 2 NF: 37 Total: 39</p> <p>Census payor type: Medicare: 2 Medicaid: 37 Total: 39</p> <p>Sample: 4</p>	F000000	<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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F000221 SS=D	<p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on record review and interview, the facility failed to ensure a resident was not restrained for the purpose of staff convenience for 1 of 4 residents reviewed for possible restraint use in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 6/3/14 at 10:50 a.m. Diagnoses for the resident included, but were not limited to, end stage dementia with anxiety, behavioral disturbances, Alzheimer's type dementia with delusions, and debility.</p> <p>A quarterly minimum data set (MDS) assessment for Resident #B, dated</p>	F000221	Resident B did not experience any negative outcome related the alleged deficient practice. The CNA who tied the sleeves together no longer works at the facility. All other residents have the potential to be affected. They have been observed and their clinical record reviewed. If concerns were found, corrective action was implemented. The facility's policy for Physical Restraints has been reviewed and no changes are indicated at this time (See Attachment A). The nursing staff has been re-educated on the restraint policy with a special focus on not restraining a resident for staff convenience (See Attachment B). A Staff Interview form has been implemented (See Attachment C). The DON or designee will be responsible for	06/10/2014

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	<p>5/22/14, indicated the resident was moderately cognitively impaired and was totally dependent on the staff for bathing, toileting, and dressing.</p> <p>A recapitulation of physician's orders, dated 5/5/14, lacked any orders for a restraint for the resident.</p> <p>Review of a facility reportable incident for the resident, dated 5/22/14, indicated on 5/21/14 at 2:10 p.m., the resident had been found in his bed with his shirt sleeves tied together and the resident could not get his hands out. The report indicated the CNAs involved were CNA #1 and CNA #2.</p> <p>The section on the reportable form for "Follow-up" indicated CNA #2 had witnessed CNA #1 tie the sleeves of the resident's shirt together when they were providing incontinent care. The follow-up note indicated the sleeves had been tied together to prevent the resident from "playing" in his BM (bowel movement) while being given incontinent care by the two CNAs. The note indicated CNA #1 stated "At that moment it seemed like a good idea to tie the sleeves together to help all of us, I did not intend for it to harm him in any way and was in a bit of a hurry and forgot to untie the sleeves." The note indicated</p>		<p>interviewing three staff members and completing the Staff Interview form on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter on an ongoing basis. Should a concern be noted, immediate corrective action will occur. Results of these interviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.</p>		

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	<p>CNA #1 was terminated due to tying the sleeves together and CNA #2 was given re-education. The note indicated the resident had no injuries related to the event and no issues were noted when a "Mental Anguish Assessment" was completed by the staff following the incident.</p> <p>CNA #2 was interviewed on 6/3/14 at 1:35 p.m. She indicated she had observed CNA #1 tie the sleeves of Resident #B's shirt together, on 5/21/14 around 2:10 p.m., in order to prevent him from putting his hands in BM while they were cleaning him up. She indicated she had told CNA #1 that she would hold his hands, but CNA #1 was already in the process of tying the sleeves together. CNA #2 indicated they had never meant to hurt him or be mean to him in any way, they just wanted to keep his hands out of the BM. She indicated when they were finished cleaning him up, she bagged all of the soiled linens and took them from the room. She indicated CNA #1 was still finishing care with Resident #B when she left the room and she thought CNA #1 would untie the shirt sleeves prior to leaving the room. She indicated she was unaware the sleeves had not been untied until it was discovered by another staff member approximately one hour after they had</p>			

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	<p>completed the incontinent care. She indicated it was never their intention to leave his shirt sleeves tied together and CNA #1 had forgotten to untie them because they were in a hurry and had a lot to get done. CNA #2 indicated she had never done this before and had never seen CNA #1 use this method to restrain the resident's hands prior to that date. She indicated she was very remorseful and never intended to harm and/or make the resident uncomfortable.</p> <p>Review of the current facility policy, dated 8/05, titled "Physical Restraint Use and Application", provided by the RN Consultant on 6/4/14 at 11:05 a.m., included, but was not limited to, the following:</p> <p>"Policy: It is the policy of this facility to prohibit the use of restraints for the purpose of discipline or convenience. Restraint use will be limited only to circumstance in which the resident has medical symptoms that warrant the use to assist in reaching and/or maintaining their highest level of functioning....</p> <p>Assessment/Evaluation:</p> <p>1. Prior to initiation of a restraint, the licensed nurse will complete an assessment to indicate all other least</p>						

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	<p>restrictive measures that have been attempted and the outcome obtained.</p> <p>2. A physician will be consulted to discuss the circumstances which warrant the restrictive device...."</p> <p>This federal tag relates to Complaint IN00149768.</p> <p>3.1-26(b) 3.1-26(o)</p>				