

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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 Complaint IN00151176.</p> <p>Complaint IN00151176 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309, F312, F323, and F365.</p> <p>Survey dates: June 25, 26, 2014</p> <p>Facility number: 000681 Provider number: 155549 AIM number: 100286100</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 36 Total: 36</p> <p>Census payor type: Medicare: 2 Medicaid: 34 Total: 36</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000		

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: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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
F000309 SS=D	<p>Quality review completed on June 30, 2014 by Randy Fry RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received pain medication timely following the identification of two new fractures of her left lower leg for 1 of 3 residents reviewed for pain management in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 6/25/14 at 10:20 a.m. Diagnoses for Resident #B included, but were not limited to chronic pain syndrome, osteoporosis, vitamin D deficiency, and Alzheimer's disease.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/12/14, indicated Resident #B was moderately cognitively impaired and required extensive assistance of two staff members for</p>	F000309	<p>1. Resident B no longer resides at the facility 2. All other residents receiving pain medications have been reviewed and are receiving pain medications timely 3. The facility's policy for Pain Management has been reviewed and no changes are indicated at this time. The nursing staff have been re-educated on Pain Management with a special focus on timely pain medications. A Pain Management Review form has been implemented. 4. The DON or designee will be responsible for completing the Pain Management Review form to ensure pain medications are given timely. Three residents will be reviewed on scheduled work days and the Pain Management Review form will be completed as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter Should a concern be noted, immediate</p>	07/01/2014

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 06/26/2014	
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
(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>transfers and toileting. The MDS indicated the resident received both routine and prn (as needed) pain medications for chronic pain.</p> <p>A physician's order, dated 5/7/14, indicated the resident was to begin hospice services. The June 2014 Medication Administration Record (MAR) indicated the resident had an order for Norco [an oral narcotic pain medication] 7.5/325 mgs [milligrams] to be given routinely every six hours at 6 a.m., 12 noon, 6 p.m., and 12 midnight. The resident also had an order for Roxanol [a narcotic pain medication] Concentrate Solution 5 mg (0.25 milliliters-a very small amount of liquid medication) that could be given sublingually (under the tongue) every 4 hours as needed for pain.</p> <p>A facility reported "Incident Report Form", initially called in to ISDH on 6/17/14, with a follow-up report, dated 6/20/14, faxed to ISDH, included, but was not limited to, the following:</p> <p>...Brief Description of Incident: On 6/16/14, fractures were noted to [name of Resident #B] left tibia and fibula. [name of resident] was lowered to the floor by three CNAs on 6/15/14 after the staff were assisting her to stand and the</p>		<p>corrective action will occur</p> <p>Results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly as indicated</p>				

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>resident's knees buckled.</p> <p>Type of Injury/Injuries: Fracture to left tibia and left fibula..."</p> <p>The clinical record indicated the resident was seen by the Nurse Practitioner on 6/16/14 at 2 p.m. and X-rays were ordered for the resident's left hip and knee. X-ray reports received at 5:30 p.m. indicated the resident had a fracture of the left tibia and left fibula. The physician was contacted on 6/16/14 at 5:30 p.m. related to the x-rays and an immobilizer was ordered. Following family consultation an order was later received for the resident to be seen the next day by (Orthopedic facility).</p> <p>CNA #1 was interviewed on 6/25/14 at 1:55 p.m. CNA #1 indicated the resident always had discomfort when she was transferred or turned, but it appeared to be worse after the fractures were noted.</p> <p>The resident's (family member) was interviewed on 6/24/14 at 4:40 p.m. She indicated she had visited the resident on 6/16/14 around 9 p.m. (after the fractures were found on the x-rays at 5:30 p.m.) and the resident was in a lot of pain. She indicated she talked to QMA #9 and expressed concern over the resident's level of pain. The family member</p>			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>indicated QMA #9 told her the resident had not received her routine 6 p.m. pain medication as scheduled because she had spit it out. When she asked if the QMA had attempted to give the resident's liquid [sublingual] medication, QMA #9 told her "No". The family member indicated she complained to RN #5 that evening and told them the resident was in pain and needed to be given the sublingual pain medication routinely so she would be comfortable. The family member indicated the resident's leg immobilizer had not yet arrived and was not in place to immobilize her leg fractures during care.</p> <p>RN #5 was interviewed on 6/26/14 at 12:55 p.m. She indicated she was the nurse on duty when the resident's family member visited on the evening of 6/16/14. She indicated she was aware the resident spit out her routine 6 p.m. dose of pain medication. She thinks the QMA intended to give the resident the sublingual medication, but then got involved helping her with an emergency code situation for another resident. When asked what time that emergency situation was resolved and that resident was sent out to the hospital, she indicated around 7 p.m. This indicated a time period of two hours that the sublingual medication could have been given prior</p>			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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 family member's arrival and expressions of concern related to the resident's level of pain.</p> <p>The June 2014 Prn Medication Flow Sheet indicated a dose of the Roxanol pain medication was given on 6/16/14 at 9 p.m. The flow sheet indicated the resident's level of pain was identified as a six on a scale from 1 to 10 with a ten being the highest level of pain.</p> <p>Review of the current facility policy, revised 5/2011, titled "Pain Management Procedure", provided by the RN Consultant on 6/26/14 at 2:40 p.m., included, but was not limited to, the following:</p> <p>"Purpose: It is the goal of this facility to assist residents in achieving his/her optimal level of comfort by providing an effective pain management program.</p> <p>Procedure:</p> <p>...4. Having determined that the resident is experiencing pain based upon assessment, follow physician orders and/or care plan...."</p> <p>This federal tag relates to Complaint IN00151176.</p>			

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 06/26/2014	
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
(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			
F000312 SS=D	<p>3.1-37(a)</p> <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. Based on observation, record review, and interview, the facility failed to ensure a resident who needed supervision and assistance to dine received those services in accordance with her plan of care for 1 of 3 residents reviewed for assistance to dine in a sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 6/25/14 at 3:45 p.m. Diagnoses for the resident included, but were not limited to, risk for aspiration, dysphagia, anemia, and history of cerebrovascular accident with left sided weakness.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 5/5/14, indicated Resident #D was moderately cognitively impaired and required extensive assistance of one staff member for eating. The assessment indicated the resident was on a mechanically altered</p>	F000312	<p>1. Resident D has been moved to an assist table to allow staff to cue, monitor for swallowing difficulties, and assist the resident if indicated 2. All other residents requiring supervision or assistance to dine have been reviewed and are receiving these services according to their plan of care 3. The facility's policy for Feeding of a Dependent Resident has been reviewed and no changes are indicated at this time The nursing staff have been re-educated on the policy with a special focus on supervision, cueing, and offering assistance if indicated A Dining Room Monitoring form has been implemented 4. The DON or designee will be responsible for completing the Dining Room Monitoring form to ensure residents are being supervised and assisted per their plan of care The Dining Room Monitoring form will be completed on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter Should a</p>	07/01/2014			

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 06/26/2014	
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
(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>diet and had swallowing problems such as coughing and or choking during meals and/or swallowing medications.</p> <p>The June recapitulation of physician's orders, signed, but not dated, indicated the resident was to have a pureed diet with pudding thick liquids. The orders indicated the resident was to have a baby spoon with meals and her drinks were to be served in bowls. The orders also indicated the resident was to have 1:1 supervision with meals.</p> <p>A nutrition health care plan, dated 4/16/14, indicated the resident was to have a pureed diet with pudding thick liquids and staff were to "assist with meals."</p> <p>During observation of the lunch meal on 6/25/14 at 11:45 a.m., the following was observed:</p> <p>11:45 a.m.- Resident #D was up in her wheelchair in the dining room. She had built-in armrests on both sides of her wheelchair. She was in the chair leaning to the right against the armrest. Her wheelchair was at a regular dining room table and the chair could not be moved close in front of the table due to the armrests. The chair was slightly at an angle to the table so the resident could</p>		<p>concern be noted, immediate corrective action will occur Results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly if indicated</p>				

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>reach her food with her right arm/hand while leaning against the armrest. The resident was asleep and was not eating. No other residents and no staff were at the table. The resident had taken a few bits of a brown substance (later identified as thickened coffee), but had not eaten any of the other food. The resident woke up during this observation and again took a bite of the thickened coffee from the bowl. It was not easy for her to reach all the food items in this position. All of the trays had been passed and CNA #6 and CNA #7 were assisting 3 residents with eating at another table. The two CNAs were at a two different tables to the back of the resident. They could easily see the resident, but would not have been able to monitor her swallowing ability well.</p> <p>An unidentified male resident was also sitting at a regular dining room table and was not feeding himself. CNA #8 came into the dining room within a few minutes and CNA #6 asked her to assist the unidentified male resident. She sat down with the resident and began to assist him with his meal.</p> <p>12:05 p.m.- Resident #D was still in the same position and had only eaten a few bites. No cueing had been given. CNA #6 was overheard to tell the others, if</p>			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>[Resident #D] doesn't feed herself, we will need to feed her.</p> <p>12:14 p.m. - CNA #7 was finished feeding her resident. CNA #6 asked CNA #7 to check on Resident #D. CNA #7 indicated she needed to wash her hands which she did, then sat down by Resident #D and began to feed her. The CNA did not offer or attempt to warm up the residents food prior to feeding her. This resulted in a time period of 31 minutes the resident was observed to be sitting without staff assistance and/or direct observation of her swallowing abilities or need for assistance.</p> <p>12:25 p.m. - CNA #7 needed to leave the dining room to assist with someone else. She moved Resident #D to the food table. The food table was higher than the regular dining room tables and the resident was able to be put directly in front of the table and much closer to the table. CNA #8 was still feeding residents at that table and was present to assist Resident #D when needed. The resident picked up her spoon and began to feed herself.</p> <p>CNA #8 was interviewed on 6/25/14 at 12:27 p.m. She indicated resident D was more awake now and was "doing better now" at the new table.</p>			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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 the current facility policy, dated 2/07, titled "Feeding of Dependent Residents Procedure", provided by the RN Consultant on 6/26/14 at 2:40 p.m., included, but was not limited to, the following:</p> <p>"Purpose: That qualified personnel... will provided nourishment to all residents who cannot or will not feed themselves.</p> <p>...Procedure:</p> <p>...2. Bring equipment and prescribed diet to bedside table or assisted/dependent feeding table.</p> <p>3.... Check tray for correct food, consistency, condiments, and utensils....</p> <p>6. Alternate foods/fluids offered - using only half a spoonful or fork full. Be careful with hot foods and liquids.</p> <p>...8. Take your time. Do not rush the resident. Make sure the resident has had enough to eat and drink according to his diet.</p> <p>...10.... Report any unusual occurrences to the nurse in charge of the resident...."</p> <p>This federal tag relates to Complaint</p>			
--	---	--	--	--

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 06/26/2014	
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
(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			
F000323 SS=G	<p>IN00151176.</p> <p>3.1-38(a)(3)(B)</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 record review and interview, the facility failed to ensure a resident was safely assisted to stand for peri-care in a manner to prevent being lowered to the floor in an unsafe manner when she became weak and her legs buckled resulting in contact with the floor and two fractures of the right lower extremity for 1 of 1 resident reviewed for a fracture following being lowered to the floor in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 6/25/14 at 10:20 a.m. Diagnoses for Resident #B included, but were not limited to chronic pain syndrome, osteoporosis, vitamin D deficiency, and Alzheimer's disease.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/12/14, indicated</p>	F000323	<p>1. Resident B no longer resides at the facility 2. All other residents requiring assistance with transfers has been reviewed and are being transferred with a gait belt and per their individual plan of care 3. The facility's policy for Transferring a Resident from Bed to Chair has been reviewed and no changes are indicated at this time The nursing staff have been re-educated on the policy with a special focus on utilizing a gait belt and following the individual's plan of care A Transfer Observation form has been implemented 4. The DON or designee will be responsible for observing three residents on schedule work days to ensure transfers are being completed appropriately and will complete the Transfer Observation form These observations will occur on alternating shifts as follows: daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter Should</p>	07/01/2014			

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 06/26/2014	
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
(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>Resident #B was moderately cognitively impaired and required extensive assistance of two staff members for transfers and toileting. The MDS indicated the resident had impairment in range of motion of bilateral upper and lower extremities. The MDS indicated the resident was not steady from a seated to standing position without staff assistance.</p> <p>A physician's order, dated 5/7/14, indicated the resident was to begin hospice services. Hospice orders, dated 5/8/14, indicated the resident was a fall risk. The orders indicated "Use 2 person assistance and gait belt for all transfers." A hospice "Safe Handling and Movement" assessment indicated the "Patient's Level of Assistance" was "Dependent-Patient requires staff to lift more than 35 pounds of the patient's weight, or is unpredictable in the amount of assistance offered. In this case assistive devices should be used." The assessment indicated 2 staff were needed to transfer/turn the resident and a gait belt should be used.</p> <p>A facility reported "Incident Report Form", initially called in to ISDH on 6/17/14, with a follow-up report, dated 6/20/14, faxed to ISDH, included, but was not limited to, the following:</p>		<p>a concern be noted, immediate corrective action will occur Results of these observations and any corrective actions taken will be discussed during the facility's quarter QA meetings and the plan adjusted accordingly</p>				

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>...Brief Description of Incident: On 6/16/14, fractures were noted to [name of Resident #B] left tibia and fibula. [name of resident] was lowered to the floor by three CNAs on 6/15/14 after the staff were assisting her to stand and the resident's knees buckled.</p> <p>Type of Injury/Injuries: Fracture to left tibia and left fibula</p> <p>... Follow up: On 6/15/14 at 11 am, the resident was standing with the assist of two staff members as per her plan of care. A third staff member was providing peri-care to the resident. While the resident was standing, her knees buckled and the staff lowered her to the floor. No injuries were noted at the time of occurrence and no complaints of pain. At 8 pm, there was bruising noted to the right and left shin area. The MD [medical doctor] and family were notified and the physician did not order any new treatment. On 6/16/14, the resident was seen by the nurse practitioner [NP]. The NP ordered X-rays to be done of the left knee. At 5:30 pm, X-ray results arrived at the facility indicating fractures of the left tibia and fibula. The MD was contacted and an immobilizer was ordered. Family was updated and requested an appointment be made to</p>			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>[Orthopedic facility] for the resident. The resident was being transported to [Orthopedic facility] on 6/17/14. During transport, the driver re-routed the resident to the hospital ER [emergency room] for evaluation due to pain. The resident was eventually admitted to the hospital after hospice services were stopped.</p> <p>Please note: The resident has a diagnosis of Osteoporosis and Vitamin D deficiency. There is a history of Prednisone use. There is also a history of hip and pelvic fractures. The resident was experiencing a decline both physically and mentally over the course of past 6 months and was a hospice patient while at the facility...."</p> <p>The reportable incident above included the names of the 3 CNAs providing care which will be now be referred to as CNA #1, #2, and #3.</p> <p>CNA #1 was interviewed on 6/25/14 at 1:55 p.m. CNA #1 indicated the three CNAs were attempting to change the resident's brief and provide peri-care while standing her up from her specialized wheelchair when the above noted incident occurred on 6/15/14. CNA #1 indicated she was the one who was standing the resident up and did so facing the resident with her arms under the residents arms and wrapped around</p>			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>the resident in a 'bear hug' manner. She indicated CNA #2 was present but he did not assist with standing the resident. She indicated CNA #3 was going to provide peri-care while she stood up the resident. She indicated she stood the resident up once and the resident's legs weakened and buckled and she sat her back down. She indicated she paused for a minute and then stood the resident up by herself in the same manner a second time and the resident's legs buckled again and she lowered her to the floor with the resident in a kneeling position with her legs under her body. She indicated there was a mild 'thump' when the resident hit the floor.</p> <p>CNA #1 indicated CNA #2 went and got the nurses who checked the resident. She indicated the resident did not appear to be injured at that time. CNA #1 indicated she worked until 8 p.m. that evening and helped CNA #4 transfer the resident back to bed after supper around 7:30 p.m. She indicated the two CNAs transferred the resident by lifting her under her arms and grabbing the back of her pants. She indicated the resident screamed out when the leg rest of her chair was lowered and during the transfer. She indicated the resident usually was uncomfortable during transfers and called out, but this was different and she appeared to be in more pain. When the resident was</p>			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>undressed, the CNAs noted the bruising to her legs and notified RN #5 who was on duty that evening.</p> <p>When queried if a gait belt had been used for either of the transfers noted above, CNA #1 indicated "No".</p> <p>CNA #2 was interviewed on 6/25/14 at 2:10 p.m. CNA #2 indicated he had been present on 6/15/14 when Resident #B was lowered to the floor. He indicated he was the "spotter" and had not lifted the resident until her legs buckled and he tried to help. He indicated she went down in a kneeling position and made contact with the floor. He indicated the other two CNAs stayed with the resident while he went and got the nurses. When queried if a gait belt had been used while they were trying to stand the resident for peri-care, he indicated "No".</p> <p>CNA #3 was unavailable for interview. Review of her written statement related to the event was as follows:</p> <p>"I [name of CNA #3], witnessed the incident where [name of resident] got lowered to the floor.</p> <p>[CNA #1] was holding [name of resident] up so I could clean her up after she pottied. [CNA #2] was our spotter in</p>			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>case something happened. [Name of resident] went limp and just stopped helping stand, so [CNA #1] held onto her and lowered her slowly down, while [CNA #2] tried to hold [name of resident] while she went down...."</p> <p>The DoN (Director of Nursing) and Assistant DoN (ADoN) were interviewed on 6/25/14 at 4:15 p.m. Additional information was requested related to the CNAs not using a gait belt, the resident being lifted by one staff member prior to being "lowered to the floor" which resulted in left leg fractures, the CNAs continuing to transfer the resident without a gait belt later in the day after she had already been unstable and her legs had buckled during care. The facility failed to provide any additional information.</p> <p>The RN consultant was interviewed on 6/26/14 at 2:40 p.m. She indicated the facility had no specific policy for assisting a resident to stand during changing of a brief, but indicated safety measures would be the same as for a resident transfer.</p> <p>Review of the current facility policy, dated 9/05, titled "Transferring a Resident from Bed to Chair", provided by the RN Consultant on 6/26/14 at 2:40</p>			

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 06/26/2014	
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
(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			
F000365 SS=D	<p>p.m., included, but was not limited to, the following:</p> <p>"...Procedure:</p> <p>...8. Apply gait belt to waist if resident requires weight bearing assist. (see gait belt procedure)</p> <p>9. Using gait belt-grasp sides of belt with both hands and assist resident to standing position; pivot turn and sit resident in chair...."</p> <p>This federal tag relates to Complaint IN00151176.</p> <p>3.1-45(a)(2)</p> <p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record review and interview, the facility failed to ensure food was served in a form to meet the resident's needs and in accordance with physician's orders for 1 of 4 residents reviewed for serving of diets as ordered in a sample of 4. (Resident #B)</p> <p>Findings include:</p>	F000365	<p>1. Resident B is no longer at the facility</p> <p>2. All other residents have been reviewed and are receiving their diets as ordered</p> <p>3. The facility's policy for Physician's Orders has been reviewed and no changes are indicated at this time The nursing staff have been re-educated on the policy with a special focus on communicating with dietary when a diet order</p>	07/01/2014			

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 06/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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>The clinical record for Resident #B was reviewed on 6/25/14 at 10:20 a.m. Diagnoses for Resident #B included, but were not limited to chronic pain syndrome, osteoporosis, vitamin D deficiency, and Alzheimer's disease. The clinical record indicated the resident was a hospice patient.</p> <p>The resident's family member was interviewed on 6/24/14 at 4:40 p.m. She indicated the resident had declined in health during the last few months and was no longer able to eat a regular diet. She indicated the family had requested a diet change and she thought the facility had obtained an order, but the resident continued to receive a regular diet.</p> <p>A physician's order, dated 5/23/14, indicated the resident was to receive a mechanical soft diet instead of a regular diet.</p> <p>The Dietary Manager was interviewed on 6/26/14 at 1:25 p.m. She indicated the family had expressed their concerns over the resident's diet during a recent conference held after the resident had been lowered to the floor by the staff while care was being provided. She indicated she was unaware of the change in the resident's diet order until that time.</p>		<p>changes A Physician's Order Review form has been implemented 4. The DON or Designee will be responsible for completing the Physician's Order Review form to ensure diets are served as ordered Reviews will be completed on three residents on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter Should a concern be noted, immediate corrective action will occur Results of these reviews and any corrective actions taken will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly as indicated</p>	

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 06/26/2014
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302		
(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>She indicated the resident had always been served a regular diet prior to her admission to the hospital on 6/17/14. She indicated she had checked her office and files after the conference with the family and was unable to find any copy of the 5/23/14 physician's order or information provided by the nursing department requesting the diet change.</p> <p>Review of the current facility policy, dated 9/05, titled "Physician's Orders Procedure", provided by the RN Consultant on 6/26/14 at 2:40 p.m., included, but was not limited to, the following:</p> <p>"...Procedure...</p> <p>5. ... Follow order through to completion--make appointments, order labs, notify pharmacy, etc..."</p> <p>This federal tag relates to Complaint IN00151176.</p> <p>3.1-21(a)(3)</p>				