

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 08/10/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00206917 and IN00206609.</p> <p>Complaint IN00206917- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00206609- Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226 and F323.</p> <p>Survey dates: August 9 and 10, 2016</p> <p>Facility number: 000310 Provider number: 155443 AIM number: 100288970</p> <p>Census bed type: SNF: 51 Total: 51</p> <p>Census payor type: Medicare: 6 Medicaid: 39 Other: 6 Total: 51</p> <p>Sample: 5</p>	F 0000	<p>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.</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.

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F 0225 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on August 11, 2016 by 17934.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p>			

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	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>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 to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review, and interview, the facility failed to ensure an injury of unknown origin was reported in 1 of 2</p>	F 0225	It is the policy of the facility to ensure that any injury of unknown origin that meets the reporting criteria guidelines set forth by the	08/30/2016	

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	<p>residents reviewed for injuries of unknown origin. (Resident F)</p> <p>Findings include:</p> <p>The clinical record for Resident F was reviewed on 8/10/2016 at 9:08 a.m. Diagnoses for Resident F included, but were not limited to, dementia with behaviors, diabetes type 2, major depressive disorder and cerebral aneurysm.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 6/21/2016, was reviewed on 8/10/2016 at 9:08 a.m. The MDS indicated Resident F was severely cognitively impaired with a BIMS (Brief Interview for Mental Status Score) of 0. Resident F received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 1 person physical assist, dressing bathing and hygiene- extensive assist with 1 person physical assist, ambulation -limited assist with 1 person physical assist and extensive assist with 1 person physical assist for toilet use. Resident F was always incontinent of bowel and always continent of bladder. Resident F had no impairments to range of motion in all extremities.</p> <p>Review of the nursing note dated</p>		<p>ISDH is reported to the ISDH timely. Resident F is being monitored per their plan of care. Any injury of unknown origin that would meet reporting criteria guidelines as set forth by the ISDH for Resident F or any other resident will be reported to the ISDH per regulation and policy. Note: The "root cause" of the injury to Resident F, based on results of the investigation including interviews and examination of the resident's room was felt to have been an unassisted fall which the resident initiated herself. Therefore, the facility did not categorize the injury as from an "unknown" origin. Resident who reside in the facility have the potential to be affected by this finding. At the daily CQI meetings all falls or injuries of unknown origin documented (as in the progress notes) or reported to the Nursing Leadership or to the Administrator since the previous CQI meeting will be reviewed. Falls will be reviewed using the Falls QA Audit Tool. This will be a double check to ensure that any injury of unknown origin or fall which results in an outcome of reportable criteria guidelines as set forth by the ISDH was in fact reported to ISDH as per policy and state regulation. While falls within injury are to be reported as they occur to the DON/Designee and to the Administrator who will</p>		

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	<p>6/11/2016 at 2:30 a.m., indicated the following: "Writer seen resident walking down 200 hallway with walker fully dressed. Write asked resident if there was something that res needed help with. Res stated she was coming down for breakfast, writer [sic] noticed blood coming down residents [sic] L (left) side of neck. Writer assisted resident back to room to assess resident. As writer approached res room a puddle of blood was noted on the floor beside bathroom door. Resident states, "I was getting up to get ready for breakfast." VS (vital signs) 150/64-59-96.8 orally-18 Skin assessed. ST (skin tear) noted to L back side of head measuring 1.5cm x 0.5cm. Swelling noted around skin tear. No other injuries noted. Neurological assessment completed. PERRLA Alert. Speech clear. Responds to verbal, tactile, and environmental stimuli. ON [sic] call paged and made aware N.O. received. (Name of lab) aware. (Name of family member) made aware. ADON aware." The nurse responsible for this note was unavailable for interview.</p> <p>During an interview on 8/10/2016 at 2:00 p.m., the Director of Nursing indicated the incident involving Resident F on 6/11/2016 was unwitnessed. The Director of Nursing indicated Resident F was cognitively impaired. The Director</p>		<p>determine if they meet reportable ISDH criteria, this will be a verification check that all follow through including notifications and reporting occurred as required. This practice will be on-going. At an in-service held for all staff on 8-30-16, the following was reviewed: A.) Resident Rights—Emphasis on Living Accommodations and Care B.) Reportable Criteria (ISDH)-- -Emphasis on Injuries of unknown origin C.) What to do if you as a staff member observe a resident who appears to be injured and it is unclear as to how the injury occurred D.) Questions/Answers Any staff who fail to comply with the points of their service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings all falls and all injuries of unknown origin since the previous QA meeting will be reviewed. If they met ISDH guidelines for reporting, this too will be reviewed to see that all appropriate actions/notifications/reporting did in fact take place. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.</p>		

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F 0226 SS=D Bldg. 00	<p>of Nursing indicated it was assumed Resident F sustained the head wound due to a fall. The Director of Nursing also indicated Resident F was able to make some needs known at times, but could not be considered a reliable source of information.</p> <p>During an interview on 8/10/2016 at 1:33 p.m., the Administrator indicated all injuries of unknown origin are reported however, the facility investigation was completed and the head injury was thought to have been caused by a fall. The Administrator indicated Resident F was cognitively impaired and the incident was unwitnessed.</p> <p>This federal tag relates to Complaint IN00206609.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit</p>			

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	<p>mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review, and interview, the facility failed to ensure facility policy was implemented and the staff identified an injury of unknown origin related to a head wound of a cognitively impaired resident. This deficient practice effected 1 of 2 residents reviewed for injury of unknown origin. (Resident F)</p> <p>Findings include:</p> <p>The clinical record for Resident F was reviewed on 8/10/2016 at 9:08 a.m. Diagnoses for Resident F included, but were not limited to, dementia with behaviors, diabetes type 2, major depressive disorder and cerebral aneurysm.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 6/21/2016, was reviewed on 8/10/2016 at 9:08 a.m. The MDS indicated Resident F was severely cognitively impaired with a BIMS (Brief Interview for Mental Status Score) of 0. Resident F received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 1 person physical assist, dressing bathing and hygiene- extensive assist with 1 person physical assist, ambulation -limited assist with 1 person</p>	F 0226	<p>It is the policy and expectation of the facility that policies in place are implemented and followed. This includes identification of injuries of unknown origin and making sure all notifications are made and that these injuries of unknown origin are reported to the ISDH if they meet reporting guidelines criteria set forth by the ISDH as per policy and state regulation. All injuries of unknown origin will be appropriately investigated in an effort to determine the "root cause." Appropriate action will be taken by the facility including any needed interventions to the plan of care.</p> <p>Residents who reside in the facility have the potential to be affected by this finding.</p> <p>Note: Their servicing and monitoring and follow up for this F-tag is included in the response for F-225.</p>	08/30/2016

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	<p>physical assist and extensive assist with 1 person physical assist for toilet use. Resident F was always incontinent of bowel and always continent of bladder. Resident F had no impairments to range of motion in all extremities.</p> <p>Review of the nursing note dated 6/11/2016 at 2:30 a.m., indicated the following: "Writer seen resident walking down 200 hallway with walker fully dressed. Write asked resident if there was something that res needed help with. Res stated she was coming down for breakfast, writer [sic] noticed blood coming down residents [sic] L (left) side of neck. Writer assisted resident back to room to assess resident. As writer approached res room a puddle of blood was noted on the floor beside bathroom door. Resident states, "I was getting up to get ready for breakfast." VS (vital signs) 150/64-59-96.8 orally-18 Skin assessed. ST (skin tear) noted to L back side of head measuring 1.5cm x 0.5cm. Swelling noted around skin tear. No other injuries noted. Neurological assessment completed. PERRLA Alert. Speech clear. Responds to verbal, tactile, and environmental stimuli. ON [sic] call paged and made aware N.O. received. (Name of lab) aware. (Name of family member) made aware. ADON aware." The nurse responsible for this note was</p>			

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	<p>unavailable for interview.</p> <p>Review of a "Pain Review dated 6/11/2016 at 2:30 a.m., indicated Resident F complained of pain and was medicated with an as needed pain medication.</p> <p>Review of a written statement dated 6/16/2016 indicated LPN #7 noted a CNA reported Resident F jumped and complained of pain when her back was touched. MD was notified and an order for an in house x-ray was received.</p> <p>During an interview on 8/10/2016 at 2:00 p.m., the Director of Nursing indicated the incident involving Resident F on 6/11/2016 was unwitnessed. The Director of Nursing indicated Resident F was cognitively impaired. The Director of Nursing indicated it was assumed Resident F sustained the head wound due to a fall. The Director of Nursing also indicated Resident F was able to make some needs known at times, but could not be considered a reliable source of information.</p> <p>During an interview on 8/10/2016 at 1:33 p.m., the Administrator indicated all injuries of unknown origin are reported however, the facility investigation was</p>			

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F 0323 SS=G Bldg. 00	<p>completed and the head injury was thought to have been caused by a fall. The Administrator indicated Resident F was cognitively impaired and the incident was unwitnessed.</p> <p>Review of a current policy dated 9/15/13, titled "Abuse Prevention Program" indicated the following: "...Abuse Reporting Policy ... All personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect, including injuries of unknown origin. (An injury should be classified as an "injury of unknown origin" when the source of the injury was not observed or known by any person, and the initial Risk Management investigation could not determine the cause of the injury. [sic] ..."</p> <p>This federal tag relates to Complaint IN00206609.</p> <p>3.1-28(a)</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</p>				

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	<p>receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to provide appropriate transfer technique for a dependent resident which resulted in a fall causing left femur fracture. This deficient practice effected 1 of 4 residents reviewed for falls. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 8/9/2016 at 9:52 a.m. Diagnoses for Resident D included, but were not limited to, encephalopathy, dementia with behaviors, diabetes type 2, psychotic disorder with delusions and epilepsy.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/10/2016, was reviewed on 8/9/2016 at 9:52 a.m. The MDS indicated Resident D was severely cognitively impaired with a BIMS (Brief Interview for Mental Status Score) of 0. Resident D received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 2 person physical assist, dressing bathing and hygiene- extensive assist with 2 person physical assist, eating- extensive assistance with one person assist and extensive assist with two person physical assist for toilet use.</p>	F 0323	<p>It is the policy of the facility to see that appropriate transfer technique is used to transfer dependent residents. Resident D no longer resides in the facility. Residents who reside in the facility and who require assistance with transfers have the potential to be affected by this finding. A facility wide audit was conducted at which time a targeted list of residents who require assistance for transfer was compiled. These residents had their medical records reviewed to ensure that the following was in place/current/correct based on their individual transfer requirements for safety: A.) Orders B.) Assessments C.) Care Plans D.) CNA Assignments E.) Necessary equipment available and in good repair for safe transfers—Ex: Mechanical Lifts/Gait belts The DON/Designee will monitor 15 residents (who need assistance with transfers) weekly on various shifts (and to include some weekend days) during their transfers to see that proper technique is practiced. Special emphasis (on at least 10 of the 15) will be on transfers that require the assist of 2 staff and/or the use of a Mechanical Lift. Any concerns will be corrected prior to a breach in technique being performed. This monitoring will continue until 4 consecutive</p>	08/30/2016

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	<p>Resident D was always incontinent of bowel and bladder. Resident D had no impairments to range of motion in all extremities. Resident D was also being seen by hospice.</p> <p>Review of clinical record also indicated a fall care plan dated 11/16/2013, intervention included, but were not limited to, two person assist with transfers.</p> <p>Review of the "Fall Risk Assessment" dated 8/1/2016 indicated Resident D was a high risk for falls with a score of 11.0.</p> <p>Review of the nursing note dated 7/30/2016 at 5:30 p.m., indicated the following: "this [sic] nurse was called to resident room D/T (due to) resident being on the floor. CNA staff stated she was getting resident from bed she had him stand up resident then dropped his legs and refused to stand and that she was not strong enough to get him from his bed to chair, staff then lower [sic] him to the floor. upon [sic] walking into resident room this nurse noticed that resident was lying on his left side with bilat feet under the bed. resident [sic] did not have on gait belt, no stand up lift was in the room, VS (vital signs) obtained 105/60, 66, 79, 18, 98.5 (A), skin assessed swollen area noted to left lower leg below the knee,</p>		<p>weeks of zero negative findings are achieved. Afterwards, 5 residents who require assistance with transfers will be monitored weekly (at least 3 will require the assist of 2 staff to transfer and/or the use of a Mechanical Lift. This monitoring will continue for a period of at least 6 months to ensure ongoing compliance. After that, random monitoring will occur. At an in-service held on 7-30-16 and 8-30-16, for nursing staff the policy and procedure for transfer techniques was reviewed. This included 1 and 2 assists plus Mechanical Lift transfers. Note: The nursing staff had received transfer training from the Invacare representative on 8-4-16. The training was "hands on" and participatory. All staff who fail to comply with the points of their in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings any falls/injuries involving a concern with transfers will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolved.</p>		

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	<p>resident C/O (complain of) pain to area PRN (as needed) med offered and refused, MD notified new orders received and carried out, (name of imaging company) notified, claim #XXXXXXXX, family and pharmacy notified."</p> <p>Review of the facility's incident investigation indicated the resident fell on 7/30/2016 at 4:23 p.m. when a CNA attempted to transfer Resident D without assistance from another staff member. Resident D was assessed and an x-ray of the left leg was ordered and obtained. The x-ray results indicated Resident D had a distal left femur fracture. Hospice and the POA were notified and Resident D was sent to the hospital. Resident D was admitted to the hospital to be evaluated for surgery.</p> <p>Review of the CNA pocket work sheet indicated Resident D was a two person assist with transfers.</p> <p>Review of the follow-up investigation dated 8/4/2016, indicated the facility suspended the CNA pending investigation. After the investigation was completed the CNA was terminated for failure to follow policy and procedure for safe transfer of a resident and poor work quality.</p>						

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(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 interview on 8/9/2016 at 12:56 10:56 a.m., LPN #1 indicated on 7/30/2016 a CNA requested help getting Resident D off the floor. "She said she was transferring him to the chair and he started going down and she wasn't strong enough to hold him." LPN #1 indicated the CNA did not have a gait belt on Resident D nor did the CNA use a mechanical lift. LPN #1 indicated Resident D was a two person assist with transfers. "The CNA's have pocket work sheets that tell them what every resident needs as far as type of transfers and how much assistance they need for toileting and such. I asked her where her gait belt and pocket work sheet were and she said she didn't know. Anytime you transfer anyone with a stand up lift or assist with ambulation, turn and pivot, we are to use a gait belt. And we are to always have two people with any of the mechanical lifts. (Resident D's name) was always a two person assist." LPN #1 indicated the CNA pocket worksheets were always kept up to date.</p> <p>During an interview on 8/9/2016 at 1:08 p.m., QMA #3 indicated the following: "I went and helped (LPN #1), the nurse on that day, to get him up. No mechanical lift was in the room. No gait belt was on the resident. He was a two</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 08/10/2016
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	<p>person assist. There should be two people assisting him with transfers at all times, because of his behaviors and he can 't stand well at times. As far as I now he had always been a two person assist."</p> <p>During an interview on 8/9/2016 at 2:16 p.m., CNA #10 indicated the CNA pocket work sheets were kept up to date and current. CNA #10 indicated the facility had educated the nursing staff to always use two people to transfer with all mechanical lifts. "I know to find help. If the work sheet says two people, I get help."</p> <p>During an interview on 8/9/2016 at 2:18 p.m., LPN #7 indicated the facility provides up to date pocket work sheets for the CNAs. LPN #7 indicated all mechanical lifts should always be performed with two staff members. "We all know to use two people for the mechanical lifts always."</p> <p>During an interview on 8/9/2016 at 3:00 p.m. the Director of Nursing indicated the CNA who transferred Resident D should have had two people and should have followed the directive of the pocket work sheet. The Director of Nursing indicated the facility recognized the deficient practice and had mandatory staff education on the use of mechanical lifts</p>			

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	and appropriate transfers. "We even had the (name of company) representative come in to do the inservices to make sure everyone knows how to operate the lifts safely." This Federal tag relates to Complaint IN00206609. 3.1-45(a)(2)				