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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/12/2015 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MUNCIE | STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304 |
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| F 000 Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00168668 and IN00168877.</p> <p>Complaint IN00168668 - Substantiated. Federal/State deficiency related to the allegation is cited at F332.</p> <p>Complaint IN00168877 - Substantiated. Federal/State deficiency related to the allegation is cited F309.</p> <p>Survey dates: March 11 and 12, 2015.</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Survey team: Shelley Reed, RN</p> <p>Census bed type: SNF/NF: 100 Total: 100</p> <p>Census payor type: Medicare: 4 Medicaid: 81 Other: 15 Total: 100</p> <p>Sample: 3</p> | F 000 | | |
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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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| F 309 SS=D Bldg. 00 | <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3-1.</p> <p>Quality review completed on March 16, 2015 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 observation, interview and record review, the facility failed to identify and manage pain following a fall. This failure was evidenced by inaccurate documentation and assessment of pain for 1 of 3 residents reviewed for accidents. (Resident C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 3/12/15 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, secondary Parkinsonism, arterial fibrillation, congestive heart failure and asthma.</p> | | | F 309 | <p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, the Plan of Correction is not an admission that a deficiency existed or that one was cited correctly. The Plan of Correction is being submitted to meet state and federal law. Resident C has returned from the hospital and is ambulating short distances with his walker. He is in Physical Therapy and making gradual progress. He continues to eat in the dining room and socialize with his friends and visit his wife on the Alzheimer's Unit and is basically back to his prior activity level. He has been educated on medication for pain and has agreed to take it when he feels he needs it, although he still</p> | | 04/11/2015 |

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| | <p>Minimum Data Set (MDS) assessment, dated 1/23/15, indicated a Brief Interview Mental Status (BIMS) score of 12; indicating the resident was moderately impaired. The resident required extensive, 1 person physical assist to transfer.</p> <p>Resident C's Fall Risk Care Plan related to Parkinson's Disease, initiated 7/21/14 and updated on 2/20/15, indicated, "No Fall related injuries through next review." The interventions indicated, "Resident will call for assist if feeling unsteady."</p> <p>During an observation for Resident C on 3/11/15 at 3:55 p.m., he was asleep in the recliner and his call light was in reach.</p> <p>An observation on 3/12/15 at 8:50 a.m., Resident C was asleep in his recliner.</p> <p>During an interview on 3/12/15 at 2:45 p.m., Resident C indicated he fell while transferring and hurt his back and ribs. He indicated he had fallen before.</p> <p>Review of a Progress Note dated 2/27/15 at 1:00 p.m., indicated Resident C was found sitting on top of his walker in the doorway of his bathroom. Resident C's vital signs were within normal limits. He was alert, oriented and had range of motion to all extremities. The physician</p> | | <p>states he likes to "tough it out." The 2567 verifies that the resident did deny pain after the fall on 2/27 multiple times, 2:25 pm, 6:00 pm, and on 3/28/15 at 2:08 am. At 5:04 pm the resident again denied pain. This indicated that the nurses were aware of the potential for pain and repeatedly assessed the resident following the 2/27/15 and 2/28/15 falls and he denied pain. On 3/1/15 the resident complained of discomfort. The surveyor spoke with Nurse RN #2 who stated she assessed resident C at 6:45 am when he was attempting to move from the recliner to the bathroom. She stated he appeared to be in pain and she administered pain medication at that time, contacted the physician again and received orders for STAT X-Rays. Becasue the mobile X-Ray company was delayed becasue of weather, he was sent to the Emergency Room for further evaluation and treatment. Nurse #1 received verbal teaching regarding completion of the pain assessment post fall. She will receive further formal training with other nurses prior to April 11th as the facility is transitioning to a computerized pain assessment which will go into effect on April 15, 2015. The electronic assessment takes a more in depth look at pain and requires a signature and date. Since other residents could be affected with</p> | |

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| | <p>was notified and no orders were received. Resident C denied pain on 2/27/15 at 2:26 p.m., 6:00 p.m. and again on 2/28/15 at 2:08 a.m.</p> <p>On 2/28/15 at 6:10 a.m., Resident C was found in his room on the floor. A skin assessment indicated the following: 4.0 cm x 2.0 cm right elbow skin tear, 4.0 cm x 4.0 cm left elbow skin tear, 8.0 x 0.5 and 2.0 cm and 1.0 cm abrasion to his lower back. LPN #1 applied Steri Strips to his elbows and notified the physician, Director of Nursing (DON) and family.</p> <p>On 2/28/15 at 5:04 p.m., a Progress Note indicated Resident C appeared confused, but denied pain.</p> <p>On 3/1/15 at 12:30 a.m., Resident C was assisted up to the bathroom. Blood was noted on bilaterally on his sleeves and back area. A large discolored, dark purple area from his wrist to upper arm with open area on the right inner elbow was noted. The left posterior elbow was noted to have a skin tear with a small amount of red drainage. His left upper back had a scant amount of bloody drainage. The dressing was changed on all 3 areas and was tender to touch.</p> <p>A Progress Noted dated 3/1/15 at 6:45 a.m., indicated Resident C complained of</p> | | <p>post fall pain, all falls are reviewed daily in Stand Up meeting to assure the pain assessment was completed accurately and completely and that pharmacological and non-pharmacological interventions were completed as appropriate based on pain levels. Pain related to falls will be tracked monthly by QAPI for 6 months and as as needed thereafter.</p> | | | | |

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| | <p>discomfort to his bilateral hips, shoulders and elbows. A 3.0 cm x 3.0 cm dark purple bruise was noted to the left hip with minimal swelling. The nurse was unable to assess range of motion related to complaints of pain. Resident C's speech was slurred more than usual and he complained of not feeling well. The resident received pain medication as prescribed and the physician was notified. A new order was received to multiple x-rays. A stat order was called to the contracted facility. Resident C's family was notified.</p> <p>At 10:30 a.m., the radiology company indicated they were unable to come related to bad weather. The physician and family were notified and the family requested the resident be sent to the emergency room. Resident C was transferred to the hospital at 11:05 a.m.</p> <p>Review of a hospital History and Physical dated 3/1/15, indicated Resident C had a fall on 2/28/15 and complained of left-sided back pain. The assessment indicated his temperature was 98.1, pulse 76, respiration 18, saturation 97% and blood pressure 103/75. His pupils were reactive and his left back was noted to have a laceration. An x-ray showed a nondisplaced left L2 transverse process fracture.</p> | | | |

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| | <p>Review of the Fall Report filled out by LPN #1, indicated Resident C complained of pain back that was throbbing and intermittent. No additional information was provided on the form. The form was not dated or signed.</p> <p>Review of the February 2015 Skin Sheets, on 2/28/15 a 4.0 cm x 2.0 cm right elbow skin tear was noted. The treatment listed was steri-strips to wound. A 4.0 cm x 4.0 cm skin tear was noted to the left elbow. The treatment listed was steri-strips to wound. An abrasion to the lower back was noted, but no size or treatment was listed.</p> <p>During a phone interview on 3/12/15 at 1:05 p.m., LPN #1 indicated the resident had complained of pain, but declined any medication. She stated she did fill out the Fall Report that indicated the resident complained of throbbing back pain.</p> <p>Review of the Progress Notes did not indicate any offer or treatment declined of pain medication for 2/28/15.</p> <p>Review of the Medication Administration Record (MAR) did not indicated any pain medication had been given on 2/28/15.</p> <p>During an interview on 3/12/15 at 2:00</p> | | | |

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| | <p>p.m., RN #2 indicated when she assessed Resident C at 6:45 a.m. on 3/1/15, he appeared to have been in pain. She stated he was attempting to move from the recliner to the bathroom. She indicated she gave pain medication and notified the physician. The physician ordered x-rays to be done.</p> <p>2. A review of the current policy titled "Falls Change of Condition Guideline for Completion," dated 11/13/14, was provided by the Administrator on 3/12/15 at 4:20 p.m., and indicated the following:</p> <p>"GUIDELINE STATEMENT: To assess individual condition after a fall occurs and to identify the reason and/or risk factors for the fall...</p> <p>Procedure:</p> <p>If a resident falls...</p> <p>1. The licensed nurse will assess the resident for injuries and provide the necessary emergency treatment...</p> <p>Sign and Date with the time completed.</p> <p>No further information was provided upon exit on 3/12/15.</p> | | | |

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| F 332 SS=D Bldg. 00 | <p>This Federal tag is related to Complaint IN00168877.</p> <p>3.1-37(a)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were administered without error. This was evidenced by 1 of 3 residents reviewed for correct medication administration. (Resident B) (RN #3)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 3/11/15 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, dementia, muscle wasting, hypertension, depressive disorder, macular degeneration and hospice.</p> <p>Minimum Data Set (MDS) assessment, dated 1/29/15, indicated a Brief Interview Mental Status (BIMS) score of 11; indicating the resident was moderately impaired. The resident required extensive, 1 person physical assist to</p> | F 332 | Resident B is alert and confused as is her long time diagnosis, having previously been a resident on the Alzheimer's Unit where she resided until her physical needs outweighed her needs associated with her dementia, and she was transferred to the skilled unit for care. She is currently on Hospice. The daughter does not feel that the resident has pain but pain symptoms have been demonstrated as well as verbal statements of pain by the resident. Daughter thinks the Morphine makes her "bug eyed" and causes her to hallucinate, and because she (the daughter) had a bad reaction to Morphine, she is afraid her mother will also. The documentation is silent as to any of these symptoms. Hospice had decreased the Morphine to twice daily on 2/10/15 in consultation with the Hospice physician at the daughter's request. On 2/13/15 the Hospice | 04/11/2015 | |

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| | <p>transfer.</p> <p>Resident B's Fall Risk Care Plan related to use of medication and poor safety awareness, initiated 12/5/13 and updated on 9/25/14, indicated, "No Fall related injuries through next review." The interventions indicated, "keep family involved in all residents requests and observe for side effects of medications."</p> <p>Resident B also had a Pain Management and Monitoring Care Plan related to osteoarthritis, headache and hemorrhoids, initiated 12/5/13 and updated on 9/25/14, which indicated, "Will maintain adequate...." The interventions indicated, "administer pain medication as ordered and observe for potential medication side effects."</p> <p>During an observation on 3/11/15 at 2:45 p.m., Resident B was observed asleep in a low bed, mat on the floor and call light in reach.</p> <p>An observation on 3/11/15 at 3:55 p.m., Resident B was asleep in bed with gripper socks on.</p> <p>An observation on 3/12/15 at 8:50 a.m., Resident B sitting in a Broda chair and just finished breakfast. She was then pushed back to the nurses ' station. She</p> | | <p>nurse wrote an order to change routine Morphine to 0.5mg. sublingual twice daily. This was not questioned by facility staff as it was clearly documented the resident had pain. The order was transcribed correctly by facility nurse and was administered as per written order of the Hospice Nurse in consultation with the Hospice Medical Director. The resident felt much better on the medication to the point she attempted to ambulate and took steps which she had not done for many months which did result in a fall. Hospice charts for other residents were reviewed to make sure pain management plans are in place and consistent between Hospice and the facility and families are aware of the plan. Since all Hospice residents could be affected, the facility is requesting face to face weekly with Hospice nurses to make sure continuity of care is provided and the facility and Hospice care plan for pain management is consistent. Hospice orders are reviewed daily by nursing management. QAPI will follow monthly for 6 months and thereafter as needed to assure continuity.</p> | | |

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| | <p>was observed again at 1:45 p.m., asleep in bed.</p> <p>Review of Hospice Notes dated 2/10/15 at 1:36 p.m., indicated the hospice nurse received a call from Resident B's daughter. The daughter voiced concerns related to the Morphine causing hallucinations and stated she had witnessed several episodes over the past few days. She indicated she would like the Morphine discontinued and replaced with another pain medication. The hospice nurse discussed her concerns with the physician who then recommended the Morphine be decreased to twice daily. The daughter was updated on the medication change.</p> <p>Review of the Medication Administration Record (MAR) for February 2015, indicated Morphine Sulfate 20mg/mL was ordered on 2/3/15. Resident B received 5 mg (0.25 ml) three times daily. The order was discontinued on 2/10/15.</p> <p>On 2/13/15, Morphine 5 mg (0.25mL) was ordered twice daily. The order was discontinued on 2/13/15. Resident B received 5 doses.</p> <p>On 2/13/15, Morphine Sulfate 20mg/mL was ordered. The order indicated to give 10 mg (0.5mL) twice daily. Resident B</p> | | | |

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| | <p>received 6 doses. The order was discontinued on 2/17/15.</p> <p>Review of a Progress Note dated 2/16/15 at 10:15 a.m., indicated a loud noise was heard from Resident B's room. She was observed lying on the floor on her right side. Red drainage was noted from her forehead. Resident B voiced discomfort to her right sacral area. Resident B received the following injuries: 6.0 cm x 6.0 cm contusion to her right patella, 2.0 cm x 1.0 cm x 0.1 cm laceration to the right outer eye with drainage, 1.0 cm x 1.0 cm contusion to the right side of her forehead, 7.5 cm x 8.5 cm x 3.0 cm raised hematoma to her right knee, 1.0 cm x 0.6 cm abrasion to her right knee, 3.0 cm x 3.0 cm raised hematoma to her right elbow. The physician and family were notified of the injuries. Resident B was sent to the hospital for evaluation and returned with 6 sutures to the right side of her forehead.</p> <p>During an interview on 3/12/15 at 3:05 p.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) indicated the daughter had requested the Morphine be discontinued.</p> <p>Review of a Physician's Order dated 2/13/15 at 10:15 a.m., indicated RN #3 wrote to change "routine Morphine to 0.5</p> | | | |

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| | <p>mL sl [sublingual] BID [twice daily]."</p> <p>On 3/12/15 at 3:40 p.m., RN #3 arrived at the facility to provide care. During an interview, she reviewed her hospice notes from 2/10/15 and indicated her intention was to decrease the Morphine per family request. She indicated "that's my med [medication] error". She stated she did call the daughter and told her the medication had been decreased. She indicated she did not see Resident B on 2/13/15, but was in the building visiting another resident when she wrote the order on 2/13/15.</p> <p>A visit on 2/17/15 at 9:09 a.m., RN #3 indicated Resident B had fallen on 2/16/15 that resulted in a laceration to the head with bruising. The note indicated the Morphine had been discontinued and replace with another narcotic.</p> <p>This Federal tag relates to Complaint IN00168668.</p> <p>3.1-48(c)(2)</p> | | | | |