

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 12/19/2014
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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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F000000	<p>This visit was for the Investigation of Complaint IN00160984.</p> <p>Complaint IN00160984 - Substantiated, Federal/State deficiencies related to the allegations are cited at F323, F325 and F327.</p> <p>Survey dates: December 18 and 19, 2014</p> <p>Facility Number: 000310 Provider Number: 155443 AIM number: 100288970</p> <p>Surveyor: Betty Retherford, RN</p> <p>Census bed type: SNF/NF: 65 Total: 65</p> <p>Census payor type: Medicare: 11 Medicaid: 48 Other: 6 Total: 65</p> <p>Sample: 3</p> <p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2-3.1.</p>	F000000		
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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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F000323 SS=D	<p>Quality review completed by Debora Barth, RN.</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 an intervention to help prevent falls was in place for 1 of 3 residents reviewed for falls. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 12/18/14 at 10:55 a.m. Diagnoses for the resident included, but were not limited to, history of motor vehicle accident with frontal lobe traumatic brain injury, diabetes mellitus, epilepsy, and dementia with behavioral disturbances.</p> <p>An admission Minimum Data Set assessment, dated 10/28/14, indicated Resident #B had short and long term memory impairment and problems of inattention and delusions. The</p>	F000323	<p>F323 IMMEDIATE ACTION(S) TAKEN FOR THE RESIDENT(S) FOUND AFFECTED INCLUDE: Resident B no longer resides at the facility. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL OF BEING AFFECTED WAS ACCOMPLISHED BY: All Residents who have an alarm as an intervention for fall prevention have the potential to be affected by this finding. ACTION(S) TAKEN/SYSTEMS PUT INTO PLACE TO REDUCE THE RISK OF FUTURE OCCURRENCES INCLUDE: An audit was completed to identify all Residents who have an alarm as intervention for fall prevention. An assessment was done to be sure that the alarm was still a recommended intervention. Care Plans were updated as necessary. Further, all alarms will be monitored/documented every shift</p>	01/09/2015

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	<p>assessment indicated the resident needed the assistance of the staff for transfers and ambulation.</p> <p>Nursing note entries, dated 11/5/14, indicated the resident was having an increase in behaviors. At 1:18 p.m., he indicated he believed his food and water were poisoned. At 3:45 p.m. he swayed while walking and dropped himself down to the floor with no known injuries. The note indicated the resident's physician and family were notified of his increased behaviors.</p> <p>A nursing note, dated 11/6/14 at 6 a.m., indicated the resident continued to be anxious and confused at times. The note indicated "...Pressure alarms in bed for resident safety...."</p> <p>The next nursing note, dated 11/6/14 at 8:10 a.m., indicated "Resident found in room next to bed. Full assessment complete, change in level of consciousness observed. Unit called for resident pickup to be evaluated and treated for change in level of consciousness. Md notified, family notified. Resident to be one on one with staff until transport arrives." The clinical record indicated the resident was transported to the emergency room for evaluation at 8:30 a.m.</p>		<p>bynurses for proper placement and functionality. Any found to be not functioning properly will be immediately repaired or replaced. If not placed properly they will be immediately readjusted to proper placement. Additionally, going forward, if a Resident has a fall and has an alarm as a fall prevention intervention; the status of the alarm at the time of the fall will be included within the fall investigation documentation as far as placement and functionality. The DON/Designee will monitor and document placement and functionality of ten personal alarms 5 days weekly. In addition DON/Designee will audit nursing documentation for placement and functionality of ten personal alarms on the TAR5 days weekly. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Any concerns will be corrected as discovered. Afterwards, random audits will occur weekly. Further, as the DON/Designee review fall investigations they will monitor to see that Residents that have an alarm as an intervention to prevent falls have the status of the alarm included on the investigation as far as placement and functionality at the time of the fall. This will be ongoing.</p> <p>All staff will be inserviced as to the use of personal alarms as fall prevention interventions. This will include :</p>				

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	<p>The nursing notes and SBAR (Situation Background Assessment Recommendation) report related to the resident being found on the floor on 11/6/14 at 8:10 a.m. lacked any information related to whether the pressure alarm placed for the resident's safety was sounding at the time of the resident's fall.</p> <p>The Administrator and DON were interviewed on 12/18/14 at 2:45 p.m. Additional information was requested related to whether the resident's alarm was sounding at the time of the resident's fall on 11/6/14 at 8:10 a.m. The DON indicated she had no information to provide at that time related to the fall investigation.</p> <p>Review of a written statement provided by the Administrator on 12/19/14 at 10 a.m., dated 12/18/14 and made by the DON, indicated the following;</p> <p>"Interview with nurse present for fall on 11/6/14. Stated alarm was not sounding, but in place on bed. Unsure of why alarm was not sounding. Spoke with [name of LPN #1]."</p> <p>LPN #1 (the nurse who completed the SBAR note on 11/6/14 at 8:30 a.m.) was</p>		<p>1.What is a personal alarm? 2.Who might be a candidate for personal alarm? 3.Assessment/Care planning 4.Placement/functionality checks 5.Documentation related to personal alarms(including documentation on the fall investigation) 6.Staff's (role) related to personal alarms(according to department) 7.Discussion</p> <p>Any staff who fail to comply with the points of theinservice will be further educated and or progressively disciplined asappropriate.</p> <p>HOW CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THEPRACTICE WILL NOT RECUR: The monitoring of personal alarms by the DON/Designee willbe reviewed weekly Quality Assurance meetings. Any concerns with placement orfunctionality will have been corrected upon discovery. Any patterns will bereviewed by the QA committee . If needed, an Action Plan will be written by theQA committee and will be monitored weekly by the Administrator untilresolution.</p> <p>Date of compliance: Jan 9, 2015</p>		

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F000325 SS=D	<p>interviewed on 12/19/14 at 11:30 a.m. LPN #1 indicated she had been the "oncoming shift nurse" working on 11/6/14. She indicated Resident #B had been found on the floor by the "offgoing shift nurse" who had given report to her related to the resident being found on the floor that a.m. LPN #1 indicated the offgoing shift nurse had told her the resident's bed alarm was not sounding at the time of the fall, but she did not know why it was not sounding. LPN #1 indicated the resident was unresponsive when found and had been sent to the emergency room for evaluation and treatment.</p> <p>This federal tag relates to Complaint IN00160984.</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview,</p>	F000325	F 325	01/09/2015	

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	<p>the facility failed to ensure a resident nutritionally at risk due to an increase in paranoid behaviors was monitored for meal replacements when he ate less than 50% of his meal for 1 of 3 residents reviewed for weight loss monitoring in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 12/18/14 at 10:55 a.m. Diagnoses for the resident included, but were not limited to, history of motor vehicle accident with frontal lobe traumatic brain injury, diabetes mellitus, epilepsy, and dementia with behavioral disturbances.</p> <p>An admission Minimum Data Set assessment, dated 10/28/14, indicated Resident #B had short and long term memory impairment and problems of inattention and delusions.</p> <p>Admission orders, dated 10/21/14, indicated the resident received an 1800 calorie, no added salt diet.</p> <p>Weight records for Resident #B indicated the resident weighed 190.3 pounds at time of admission on 10/21/14. The resident weighed 189.2 pounds on 10/26/14. The resident weighed 174.8</p>		<p>IMMEDIATE ACTION(S) TAKEN FOR THE RESIDENT(S) FOUND TO BEAFFECTED INCLUDE: Resident B no longer resides at the facility.</p> <p>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL OFBEING AFFECTEC WAS ACCOMPLISHED BY: All Residents who reside in the facility have the potentialto be affected by this finding unless they are unable to maintain acceptableparameters of nutritional status such as body weight and protein levels due totheir clinical condition.</p> <p>ACTION(S) TAKEN/SYSTEMS PUT INTO PLACE TO REDUCE THE RISK OFFUTURE OCCURRENCES INCLUDE: Residents who receive meal trays have their consumptiondocumented by nursing staff. Those Residents who consume less than 50% of theirmeal are offered a substitute for that meal. The charge nurse is notified bythe nursing assistant if the Resident eats less than 50% of their meal so thatthe nurse can follow up as to why the Resident did not eat more than 50% of themeal and also to track how much of the substitute is consumed. At an inservicefor all nursing staff the requirement to document food consumption and to offera substitute for that meal to Residents who fail to consume 50% or greater oftheir meal was reviewed. Also reviewed in the inservice:</p>				

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	<p>pounds on 11/2/14. This indicated the resident had lost 14.4 pounds in 6 days.</p> <p>A nursing note, written by the Social Services Director, dated 10/30/14 at 8:59 a.m., included, but was not limited to, the following:</p> <p>"res has had multiple episodes of delusional thoughts. Resident states that the water and food is poisoned and that his drinks are mixed to alter his thinking. Res states that his meds are poisoned...."</p> <p>The nursing notes for 10/31, 11/1, 11/2, 11/3, and 11/4/14 lacked any information related to how much the resident was eating and/or drinking. The clinical record indicated the resident was seen by the Nurse Practitioner on 11/4/14.</p> <p>Nursing note entries, dated 11/5/14, indicated the resident was having an increase in behaviors. At 1:18 p.m., he indicated the believed his food and water were poisoned. The note indicated the resident's physician and family were notified of his increased behaviors.</p> <p>The next nursing note, dated 11/6/14 at 8:10 a.m., indicated "Resident found in room next to bed. Full assessment complete, change in level of consciousness observed. Unit called for</p>		<p>1.How to identify 50% or less meal intake</p> <p>2.What to do if 50% or less of meal is consumed bya Resident</p> <p>3.Whom to inform about 50% or less mealconsumption by a Resident</p> <p>4.Some reasons for decreased appetite</p> <p>5.Changes of Conditions/complications related todecreased nutritional intake</p> <p>6.Documentation related to food consumption</p> <p>7.Discussion</p> <p>The DON/Designee will monitor 50% or less meal consumptionby Residents daily to see that a substitute was offered. If the substitute wasalso refused , the DON/Designee will place the Resident on alert charting and see that the Doctor and familyand dietary supervisor are notified so that interventions can be implemented asapropriate. A Resident who has adecrease in appetite(eating 50% or less of meals for 72 hours) will be weighedand placed on weekly weights. The Residents' status will be reviewed weekly atthe Skin Weight Assessment Team meeting for further follow up and orinterventions as appropriate. This will be ongoing.</p> <p>HOW WILL THE CORRECTION ACTION(S) WILL BE MONITORED TOENSURE THE PRACTICE WILL NOT RECUR:</p> <p>The DON/Designee monitoring of</p>		

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	<p>resident pickup to be evaluated and treated for change in level of consciousness. Md notified, family notified. Resident to be one on one with staff until transport arrives." The clinical record indicated the resident was transported to the emergency room for evaluation at 8:30 a.m.</p> <p>Food consumption records for Resident #B, dated from 10/26/14 through 11/5/14 indicated the resident ate only 25 to 50% of these meals on the following dates:</p> <p>Breakfast meal on 10/28, 10/29, 11/3, and 11/4/2/14</p> <p>Lunch meal on 10/28, 11/2, 11/3, and 11/4/14</p> <p>Supper meal on 11/3 and 11/5/14. The supper meal was refused on 11/4/14.</p> <p>The clinical record lacked any information related to any alternate foods/supplements having been offered for the meals where less that 50% was eaten.</p> <p>The DON was interviewed on 12/18/14 at 2:45 p.m. She indicated alternate foods were to be offered to residents who consumed less that 50% of their meal. Additional information was requested</p>		<p>50% or less meal consumptions by Residents will be reviewed at the daily CQI meetings. Appropriate interventions will be discussed at that time, including notification to dietary, plans to monitor (alert charting), follow up and making notifications as indicated. Decisions to add the Resident to SWAT tracking can also occur at this time. At these weekly SWAT meetings, weights/nutritional concerns are addressed and interventions are initiated and care planned. Patterns or significant concerns will be addressed via an Action Plan by the QA committee to be monitored weekly by the Administrator until resolution. Date of compliance: Jan 9, 2015</p>				

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F000327 SS=D	<p>related to alternates having been offered to Resident #B for the meals in question.</p> <p>The DON was interviewed on 12/19/14 at 10:45 a.m. She indicated she had no information to provide related to alternate food replacements and/or supplements offered to Resident #B in regards to eating less than 50% of the meals in question.</p> <p>This federal tag relates to Complaint IN00160984.</p> <p>3.1-46(a)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview, the facility failed to ensure a resident refusing foods and fluids due to an increase in paranoid behaviors was monitored for sufficient fluid intake for 1 of 3 residents reviewed for hydration concerns in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was</p>	F000327	<p>F327 IMMEDIATE ACTION(S) TAKEN FOR THE RESIDENTS(S) FOUND AFFECTED INCLUDE: Resident B no longer resides at the facility. IDENTIFICATION OF OTHER RESIDENT(S) HAVING THE POTENTIAL OF BEING AFFECTED WAS ACCOMPLISHED BY: All Residents who reside in the facility who take fluids orally have</p>	01/09/2015

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	<p>reviewed on 12/18/14 at 10:55 a.m. Diagnoses for the resident included, but were not limited to, history of motor vehicle accident with frontal lobe traumatic brain injury, diabetes mellitus, epilepsy, and dementia with behavioral disturbances.</p> <p>An admission Minimum Data Set assessment, dated 10/28/14, indicated Resident #B had short and long term memory impairment and problems with inattention and delusions.</p> <p>Admission orders, dated 10/21/14, indicated the resident received an 1800 calorie, no added salt diet.</p> <p>A Nutritional needs assessment, dated 10/30/14, completed by the Registered Dietician, indicated the resident had estimated fluid needs between 2147 cc (cubic centimeters) and 2577 cc daily.</p> <p>Weight records for Resident #B indicated the resident weighed 190.3 pounds at time of admission on 10/21/14. The resident weighed 189.2 pounds on 10/26/14. The resident weighed 174.8 pounds on 11/2/14. This indicated the resident had lost 14.4 pounds in 6 days.</p> <p>A nursing note, written by the Social Services Director, dated 10/30/14 at 8:59</p>		<p>the potential to be affected by this finding.</p> <p>An audit was completed by the Dietician to determine therecommended oral fluid intake amounts for all Residents for a 24 hour period. Those Residents who consume fluids orally willconsume the recommended daily (24 hour period) fluid intake of a minimum of1500cc. The amount of fluid consumed will be documented every shift. If they donot consume the recommended amount they will be interviewed (if interviewable)as to why they did not consume the recommended volume. Fluids of their choicewill be offered. If a Resident consumes less than the minimum 1500CC dailyrecommended amount two days out of any 7 day period, they will be assessed forsigns and symptoms for dehydration using the Dehydration assessment tool. TheDoctor the Dietician and Family will be notified and new interventions will becare planned. Residents who fall below the recommended daily minimum fluidintake will be reviewed at the daily CQI meetings. The DON/Designee will audit Residents for recommended daily minimum fluid intake ona weekly basis to ensure that appropriate follow up is taking place. This willbe ongoing. Nurses will offer 240cc liquid to Residents routinely at medpasses.</p>	

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	<p>a.m., included, but was not limited to, the following:</p> <p>"res has had multiple episodes of delusional thoughts. Resident states that the water and food is poisoned and that his drinks are mixed to alter his thinking. Res states that his meds are poisoned...."</p> <p>The nursing notes for 10/31, 11/1, 11/2, 11/3, and 11/4/14 lacked any information related to how much the resident was eating and/or drinking. The clinical record indicated the resident was seen by the Nurse Practitioner on 11/4/14.</p> <p>Nursing note entries, dated 11/5/14, indicated the resident was having an increase in behaviors. At 1:18 p.m., he indicated he believed his food and water were poisoned. The note indicated the resident's physician and family were notified of his increased behaviors. The clinical record indicated the resident was transferred to the hospital on 11/6/14 when he was found unresponsive on the floor of his room.</p> <p>Fluid intake records for fluids recorded at mealtimes and from the hydration cart rounds were totaled for the dates and times as noted:</p> <p>11/1/14 - 1320 cc</p>		<p>The Hydration Cart will continue to be taken to the units at 10am and 2PM and at Bedtime at which time fluids will be offered to Residents who are not on Fluid Restriction.</p> <p>All Nursing staff were educated as to the Hydration Program including:</p> <ol style="list-style-type: none"> 1. Hydration-Benefits 2. Dehydration-signs/symptoms and complications 3. Maintaining recommended fluid intake 4. Documentation 5. Notifications if less than recommended amount of fluid is consumed. 6. Interventions/Care Plan 7. Discussion <p>HOW THE CORRECTION ACTION(S) WILL BE MONITORED TO ENSURE THE PRACTICE WILL NOT RECUR: At the daily CQI meetings monitoring of the fluid intake (minimum of 1500CC daily) of Residents will be discussed (if they fall short of consuming the recommended amount). Action will be taken as stated previously. This will be ongoing. The DON/Designee monitoring will be reviewed weekly at the QA meeting. Any patterns or concerns will be addressed by the QA committee via an Action Plan. The Action Plan will be reviewed by the Administrator weekly until resolution. Date of compliance: Jan 9, 2015</p>		

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	<p>11/2/14 - 1560 cc 11/3/14 - 960 cc 11/4/14 - 360 cc 11/5/14 - 1080 cc</p> <p>This indicated the resident might not have reached his total fluid intake needs on any of the dates in question.</p> <p>The DON was interviewed on 12/18/14 at 2:45 p.m. Additional information was requested related to monitoring of 24 hour fluid intake for Resident #B when he was eating poorly and thought his food and fluids were poisoned. The DON indicated the fluid amounts were recorded into the computer system by the CNAs along with meal documentation for the residents. The DON indicated the system did not total and record 24 hour fluid intake information needed to be used for monitoring purposes for Resident #B.</p> <p>LPN #1 was interviewed on 12/19/14 at 11:30 a.m. She indicated Resident #B had developed the problems with paranoia related to poisoned food and drink approximately a week before he was transferred to the hospital. She indicated the nurses discussed the resident's decreased food/fluid intake during shift changes, but no direct monitoring of his fluid intake on a 24</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 12/19/2014
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	<p>hour basis had been implemented.</p> <p>The facility failed to provide any additional fluid consumption information as of exit on 12/19/14.</p> <p>This federal tag relates to Complaint IN00160984.</p> <p>3.1-46(b)</p>				