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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/10/2014 |
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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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| F000000 | <p>This visit was for the Investigation of Complaint IN00158030.</p> <p>Complaint IN00158030 Substantiated. Federal/State deficiencies related to the allegations are cited at F323, F328 and F465.</p> <p>Survey dates: November 7, and 10, 2014</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 108 Total: 108</p> <p>Census payor type: Medicare: 9 Medicaid: 70 Other: 29 Total: 108</p> <p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p> | F000000 | F0000 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. This Plan of Correction is submitted to meet requirements by state and federal law. Based on ISDH Surveyor recommendation, Golden Living Center Muncie respectfully requests a paper compliance review for this Plan of Correction. | |

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 observation, record review, and interview, the facility failed to ensure interventions to help prevent falls were in place to help reduce fall risk/injury for 2 of 3 residents reviewed for falls in a sample of 5. (Resident #E and #C)</p> <p>Findings include:</p> <p>1. During an observation with the DON on 11/7/14 at 9:20 a.m., Resident #E was resting in bed. The resident's call light was hanging down from the bed and resting on the floor. The call light was not within the resident's reach. The DON obtained the call light from the floor and placed it on the resident's bed. She informed the resident where the call light was located.</p> <p>The clinical record for Resident #E was reviewed on 11/7/14 at 1:40 p.m.</p> | F000323 | Residents #C and E had their call lights immediately replaced. Clips are attached to help prevent the cords from falling to the floor. The fall mat for resident #C was replaced by the resident's bed as per the plan of care. It had been removed for cleaning. Staff have been educated to use another mat while the resident's mat is being cleaned. All other dependent residents on the unit have been identified as at risk of dropping their call lights. Clips have been attached to all call lights to help maintain them in easy reach. All other residents with orders for a floor mat have been reviewed. All mats are in place. Fall care plans were printed for all residents on the unit and the RN Week End Manager did an audit on 11/15/14 to assure all fall interventions were in place. All mats and call lights were in place as per the care plan. Staff have been educated | 11/29/2014 | |

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| | <p>Diagnoses included, but were not limited to, chronic airway obstruction, pneumonia, sleep apnea, and blindness of both eyes..</p> <p>A health care plan problem, dated 10/27/14, indicated Resident #E was at risk for falls related to medication use and blindness. One of the approaches for this problem included, but was not limited to, "call light or personal items available and in easy reach or provide reacher".</p> <p>2. During an observation conducted with LPN #3 on 11/7/14 at 2:45 p.m., Resident #C was resting on a low bed in her room. The resident's call light was not in reach. No mat was on the floor by the resident's bed.</p> <p>LPN #3 was interviewed on 11/7/14 at 2:45 p.m. Additional information was requested related to the call light not being in reach and no mat in place beside the resident's bed. LPN #3 placed the call light in reach of the resident and indicated she would check to see if the resident was supposed to have a mat on the floor by the bed. LPN #3 went to the nursing station and reviewed the clinical record. She indicated the resident was supposed to have a mat in place by her bed. She indicated she would locate a</p> | | <p>on making sure call lights are clipped in place and fall interventions are present on 11/24/14. Guardian Angel/Department Head rounds are in place to monitor ongoing compliance. Results of Guardian Angel/Department Head rounds will be monitored by the QAPI for the next three months for effectiveness.</p> | | |

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| | <p>mat for the resident.</p> <p>The clinical record for Resident #C was reviewed on 11/7/14 at 11:10 a.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease anxiety state and depressive disorder.</p> <p>A health care plan problem, revised on 9/4/14, indicated Resident #C was at risk for falls due to poor safety awareness due to dementia, osteoarthritis, pain in the joints, and general debility. Approaches for this problem included, but were not limited to, "Call light or personal items available and in easy reach, bed in low position and mat beside bed". The last two approaches were initiated on 11/2/14.</p> <p>Review of a fall investigation, dated 11/2/14, included but was not limited to the following:</p> <p>The investigation indicated the resident was found on the floor beside her bed on 11/2/14 at 7:11 a.m. The investigation indicated new interventions of a low bed and a mat on the floor would be initiated to help prevent injury from falls.</p> <p>3. Review of the current facility policy, revised 2013, titled "Falls Management Clinical Guidelines", provided by the Administrator on 11/10/14 at 8:20 a.m.,</p> | | | | |

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| F000328 SS=D | <p>included, but was not limited to the following:</p> <p>"The center implements the falls prevention and intervention program including:</p> <p>...Newly admitted/readmitted residents are assessed for fall risk by means of the Clinical Health Status tool. The Immediate Plan of Care at Risk - Falls Risk is initiated.</p> <p>...The interdisciplinary team evaluates the fall prevention plan of care for residents "at risk" for falls.</p> <p>...Appropriate interventions are implemented...."</p> <p>This federal tag relates to Complaint IN00158030.</p> <p>3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;</p> | | | |

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| | <p>Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure respiratory care equipment was stored in a manner to prevent possible contamination from viral and/or bacterial pathogens for 2 of 2 residents reviewed who received respiratory care services in a sample of 5. (Resident #D and #E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #D was reviewed on 11/7/14 at 1:20 p.m. Diagnoses for the resident included, but were not limited to, cerebral brain stem contusion related to motor vehicle accident injury, tracheostomy, and history of respiratory failure.</p> <p>The clinical record indicated the resident had a tracheostomy in place and received humidified oxygen therapy via a tracheostomy mask. The clinical record indicated the resident was on Levaquin (an antibiotic) 750 milligrams (mg) daily for treatment of pneumonia. The resident also had an order for Albuterol (a medication given to help open the airway and improve respirations) 2.5 mg/3 milliliters (ml) nebulizer treatment every two hours as needed for shortness</p> | F000328 | <p>The respiratory equipment and tubing for Resident #D was immediately discarded and new supplies bagged and labeled with name of resident and date. The nebulizer tubing and medication chamber and C-Pap mask were immediately discarded and new equipment was placed in labeled bags with the name and date to protect from contamination for resident #E. All other residents receiving respiratory treatments on the unit were identified at risk but had supplies appropriately contained in labeled bags. Staff were educated on the facility policy for maintaining respiratory equipment in a manner to prevent contamination on 11/24/14. Guardian Angel/Department Head rounds are in place to monitor that respiratory equipment is contained in a way to maintain infection control practices. Results of findings from Guardian Angel/Department Head rounds will be reviewed by the QAPI committee for three months with appropriate action taken.</p> | 11/29/2014 | | | |

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| | <p>of breath.</p> <p>During an observation conducted with the DON on 11/7/14 at 9:10 a.m., Resident #D was lying in bed with his oxygen therapy in place via his tracheostomy at 2 liters per minute with 28% humidity as ordered by the physician. A nebulizer machine and nebulizer tubing were noted on the nightstand next to the bed. The nebulizer tubing and medication chamber on the tubing (used to administer an as needed Albuterol treatment) were uncovered, open to the air, and in contact with the surface of the bedside stand.</p> <p>The DON was interviewed on 11/7/14 at 9:10 a.m. She indicated the tubing and nebulizer medication container should have been stored in a plastic bag to prevent contamination in accordance with facility protocol.</p> <p>2. The clinical record for Resident #E was reviewed on 11/7/14 at 1:40 p.m. Diagnoses included, but were not limited to, chronic airway obstruction, pneumonia, sleep apnea, and congestive heart failure.</p> <p>The clinical record indicated the resident received oxygen via a nasal cannula continuously at 2 liters per minute</p> | | | | | | |

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| | <p>(LPM). The resident was currently receiving Levaquin 750 mgs daily for treatment of pneumonia. The resident had additional respiratory care orders which included, but were not limited to, the following:</p> <p>"Albuterol Sulfate 1.25 mg/3 ml nebulizer treatment, inhale one vial via nebulizer every 8 hours for cough related to pneumonia.</p> <p>CPAP (continuous positive airway pressure) at night with oxygen at 2 LPM on at bedtime and off upon waking for hypersomnia with sleep apnea."</p> <p>During an observation conducted with RN #2 on 11/7/14 at 2:40 p.m., Resident #E was lying in bed. Oxygen therapy was in place at 2 liters per minute via nasal cannula. The nebulizer tubing and medication chamber and his CPAP mask and tubing were lying on his bedside stand. The tubings were uncovered, open to the air, and in contact with the tabletop surface.</p> <p>RN #2 was interviewed on 11/7/14 at 2:40 p.m. She indicated the nebulizer tubing and the CPAP tubing should have been stored in plastic bags to prevent contamination in accordance with facility protocol.</p> | | | | | | |

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| | <p>3. Review of the current facility policy, revised October 2011, titled "Departmental (Respiratory Therapy) - Prevention of Infection", provided by the Administrator on 11/10/14 at 8:20 a.m., included, but was not limited to, the following:</p> <p>"Purpose</p> <p>The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff.</p> <p>... Infection Control Considerations Related to Oxygen Administration</p> <p>...8. Keep the oxygen cannulae and tubing used PRN [when needed] in a plastic bag when not in use....</p> <p>Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol:</p> <p>...7. Store the circuit in plastic bag, marked with the date and resident's name, between uses...."</p> <p>This federal tag relates to Complaint IN00158030.</p> | | | | | | |

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| F000465 SS=E | <p>3.1-47(a)(4) 3.1-47(a)(6)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe and functional environment for 5 of 7 resident rooms observed during two of two environmental tours. (Rooms 210, 213, 214, 218, and 223)</p> <p>Findings include:</p> <p>During the initial tour, conducted with the DON on 11/7/14 at 9:10 a.m., the following was observed:</p> <p>Room 210B: The middle drawer of the resident's bedside stand had fallen down and was off track. This made it difficult to open the middle and bottom drawer.</p> <p>Room 213B: The resident's over the bed table had rough edges and the cork undersurface was exposed around the edge. This would prevent the table from being sanitized after care was done.</p> | F000465 | <p>The drawer in room 210B was immediately reported to the Maintenance Director for repair and was repaired on 11/7/14. The over bed table was switched out in rooms 213B and 218B with ones that had no cork showing or rough edges. The bedside table in room 223A was replaced by one that had no damage and could be appropriately sanitized. The shelving in the closet of room 210 has been repaired so that items can be safely stored. The Heating unit in room 214B was immediately reported and repaired by the Maintenance Director. Safety Rounds were conducted by the Maintenance Department to identify any other potential resident rooms with environmental concerns. No other resident rooms were found to be affected. Guardian Angel /Department Head Rounds are in place to monitor for any ongoing environmental issues. Preventative Maintenance rounds are being completed daily as well as completion of work</p> | 11/29/2014 | | | |

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| | <p>Room 214B: The exterior cover was loose and poorly connected to the heating unit beneath the windows. This allowed a gap and exposed a sharp metal edge. The DON notified a nurse on duty on the unit to call maintenance staff to the unit to fix the heater cover so that no injury could occur related to the exposed sharp metal edge.</p> <p>Room 218B: The resident's over the bed table had rough edges and the cork undersurface was exposed around the edges of the table. This would prevent the table from being sanitized after care was done.</p> <p>Room 223A: The bedside stand had several rough edges with cork undersurface exposed. This would prevent the table from being sanitized after care was done.</p> <p>The DON was interviewed on 11/7/14 at 9:30 a.m. The DON indicated the facility was aware of the need for some new nightstands and over the bed tables and they were working on this concern.</p> <p>The closet in room 210 was observed with LPN #1 on 11/10/14 at 12:05 p.m. Two shelves on the right interior side of the closet were hanging down. The shelving brackets had broken loose and</p> | | orders submitted daily. Results of the Guardian Angel/Department Head Rounds will be reviewed by the QAPI for the next three months with appropriate action taken for trends or patterns. | | |

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| | <p>the shelves were hanging down. No items could be placed on these shelves. LPN #1 indicated she would make a repair requisition out for the broken shelves.</p> <p>This federal tag relates to Complaint IN00158030.</p> <p>3.1-19(f)</p> | | | | |