

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 09/30/2014
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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 IN00156640 and IN00156844.</p> <p>Complaint IN00156640 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00156844 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226 and F323.</p> <p>Survey dates: September 29 & 30, 2014.</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: 99 Total: 99</p> <p>Census payor type: Medicare: 5 Medicaid: 71 Other: 23 Total: 99</p> <p>Sample: 7</p>	F000000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements by state and federal law.</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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F000323 SS=G	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3-1.</p> <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, interview and record review, the facility failed to ensure residents were free from accidents and hazards by failure to properly supervise dementia residents who resided in a locked unit of the facility. This deficient practice resulted in a head injury with 12 sutures for 1 of 3 residents reviewed for accidents. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident (C) was reviewed on 9/29/14 at 12:30 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, Alzheimer's disease, depressive disorder and pain.</p>	F000323	Resident C has been treated as per physician orders for wound healing and the area to his forehead has healed completely without any sign of infection or complication. Neuro checks remained within normal limits. The resident's care plan has been updated to reflect that he must be accompanied by a licensed staff member or certified nursing assistant when going outside with the Interactive Arts Director. The practice has the potential to affect all other residents on the secured unit. Therefore, the facility has adopted a policy that the Interactive Arts Director can only take residents outside when accompanied by a member of the licensed staff or by a certified nursing assistant. The Interactive Arts Director has been re-educated on Safety topics	10/19/2014			

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	<p>The Quarterly Minimum Data Set (MDS) assessment dated 8/9/14, indicated Resident (C) was severely cognitively impaired.</p> <p>During observation on 9/29/14 at 10:45 a.m., Resident (C) had a large healing wound on the forehead.</p> <p>A Progress Note dated 9/19/14 at 11:15 a.m., indicated the nurse was called outside to the courtyard. A resident was observed on the sidewalk in a prone position, holding his head. A moderate amount of sanguineous [blood] drainage was observed. Following the assessment, the wound measured 5 cm x 0.5 cm. The physician was notified and the resident was sent to the emergency room.</p> <p>Resident (C) returned to the facility with 12 sutures on his head</p> <p>Review of the Fall Investigation Report dated 9/19/14, indicated the Art Therapy Director had taken the resident outside with a visiting dog and photographer. She escorted the dog and photographer back into the lock unit and forgot to go back outside and bring Resident (C) inside. The investigation report indicated "[name of staff member] stated she left him outside alone about 20-25 min."</p>		<p>which include: Age Specific Care for the Population We Serve. Patient Mobility and Ambulation, Falls, Fires and Other Hazards, Care Basics, Food Safety and Serving. She has signed acknowledgement that she is only to take a resident outside when accompanied by a licensed or certified staff member. Other staff on the unit have been educated on the need to accompany the Interactive Arts Director when taking residents outside and stay with the resident/residents as long as they remain outside. A sign out sheet will be utilized when taking residents off the unit. This process will be monitored by the Alzheimer's Unit Director or designee Monday through Friday and by the Charge Nurses or designee on the weekends. The practice will be monitored by the QAPI for 6 months Any breach in protocol will be reviewed by facility management and appropriate action taken.</p>				

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	<p>The Fall Investigation Report also contained a written statement from LPN #2 stating "I went out to him. I was the first one out there. [name of resident] was the only one out there."</p> <p>During an interview on 9/29/14 at 11:30 a.m., the Dementia Unit Manager indicated Resident (C) was out in the courtyard when he fell and staff was with him. She indicated the resident was sent to the hospital where he received 12 sutures in his forehead.</p> <p>During an interview on 9/29/14 at 11:45 a.m., the Art Therapy Director indicated she went outside with the resident, a visiting dog and photographer. She indicated she went back inside to let the dog and photographer off the locked unit and left Resident (C) outside alone. She indicated lunch was getting ready to be served and a CNA found the resident outside.</p> <p>During an interview on 9/29/14 at 12:10 p.m., CNA #3 indicated a family member came up to her and told her a resident was on the sidewalk outside. She then went and got LPN #2 to help her.</p> <p>During an interview on 9/29/14 at 12:15 p.m., LPN #2 stated the CNA sent someone to get her to help the resident.</p>				

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	<p>She indicated the resident was alert but had moderate bleeding.</p> <p>During an interview on 9/30/14 at 9:55 a.m., CNA #6 indicated residents were often left out in the courtyard unattended.</p> <p>During an interview on 9/30/14 at 11:15 a.m., the Dementia Unit Director indicated the Art Therapy Director was assisting people off the unit and the resident was left outside and fell on the cement. He indicated it was an unusual occurrence and was not sure why it was not reported to the State. He indicated staff were not allowed to leave residents outside unattended.</p> <p>The current care plan dated 8/20/14, indicated Resident (C) had identified problems related to falls, history of falls, pain and osteoporosis. Approaches to the problem included, but were not limited to, routinely remind resident to ask for assistance when wanting to transfer and assess that wheel chair is of appropriate size; assess need to have wheelchair locked/unlocked for safety and anti-tippers.</p> <p>Review of a summary report of a meeting dated 9/22/14 titled "Strategies to reduce and prevent falls" which was provided by the Administrator on 9/30/14 at 9:00</p>				

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F009999	<p>a.m., indicated the following:</p> <p>"STRATEGIES TO REDUCE AND/OR PREVENT FALLS</p> <p>...Consistent staff, proper supervision...</p> <p>...Know what 13% fall benchmark means in your facility (How many residents with falls can you have at your facility and still stay under the benchmark? Know where you are in terms of the benchmark...</p> <p>...Prepare ahead for...there are staff members available to monitor during these times of reduced coverage."...</p> <p>This Federal tag relates to Complaint IN00156844.</p> <p>3.1-45(a)(2)</p> <p>STATE FINDINGS:</p> <p>3.1-28(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and</p>	F009999	The facility did not report this incident as the facility guidelines indicate that lacerations of 10cm. or more would be considered significant injury and reported as an unusual occurrence. Not reporting has the potential to affect all other residents involved	10/17/2014

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	<p>misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency.</p> <p>This state rule was not met, as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to report an accident that resulted in injury to the appropriate agency for 1 of 3 residents reviewed for accidents. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident (C) was reviewed on 9/29/14 at 12:30 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, Alzheimer's disease, depressive disorder and pain.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 8/9/14, indicated Resident (C) was severely cognitively impaired.</p> <p>During observation on 9/29/14 at 10:45 a.m., Resident (C) had a large healing wound on the forehead.</p>		<p>in an accident with significant injury. The Alzheimer's Unit Director, Social Worker, Unit Managers, Director of Nursing Services and Director of Clinical Education have been educated on the Abuse, mistreatment, neglect, including injuries of unknown origin policy, Investigation Protocol and notification of appropriate persons and entities as per state guidelines. The Administrator or designee will monitor via Stand Up meetings daily and the Weekend Manager or designee will monitor via Week End Stand Up. Any deviation will be reviewed by facility management and appropriate action taken. Results will be reviewed by QAPI for 6 months.</p>				

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	<p>A Progress Note, dated 9/19/14 at 11:15 a.m., indicated the nurse was called outside to the courtyard. A resident was observed on the sidewalk in a prone position, holding his head. A "moderate amount of sanguineous [blood] drainage" was observed. Following the assessment, the wound measured 5 cm x 0.5 cm. The physician was notified and the resident was sent to the emergency room.</p> <p>Resident (C) returned to the facility with 12 sutures to his head</p> <p>Review of the Fall Investigation Report, dated 9/19/14, indicated the Art Therapy Director had taken the resident outside with a visiting dog and photographer. She escorted the dog and photographer back into the locked unit and forgot to go back outside and bring Resident (C) inside. The investigation report indicated "[name of staff member] stated she left him outside alone about 20-25 min."</p> <p>The Fall Investigation Report also contained a written statement from LPN #2 stating "I went out to him. I was the first one out there. [name of resident] was the only one out there."</p> <p>During an interview on 9/29/14 at 11:30 a.m., the Dementia Unit Manager indicated Resident (C) was out in the</p>			
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	<p>courtyard when he fell and staff was with him. She indicated the resident was sent to the hospital where he received 12 sutures in his forehead.</p> <p>During an interview on 9/29/14 at 11:45 a.m., the Art Therapy Director indicated she went outside with the resident, a visiting dog and photographer. She indicated she went back inside to let the dog and photographer off the locked unit and left Resident (C) outside alone. She indicated lunch was getting ready to be served and a CNA found the resident outside.</p> <p>During an interview on 9/29/14 at 12:00 p.m., the Director of Clinical Education indicated the fall was not reported because it was clear what had happened. She indicated the resident was not outside alone at the time of the fall.</p> <p>During an interview on 9/29/14 at 12:10 p.m., CNA #3 indicated a family member came up to her and told her a resident was on the sidewalk outside. She then went and got LPN #2 to help her.</p> <p>During an interview on 9/29/14 at 12:15 p.m., LPN #2 stated the CNA sent someone to get her to help the resident. She indicated the resident was alert but had moderate bleeding.</p>			

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	<p>During an interview on 9/30/14 at 9:55 a.m., CNA #6 indicated residents were often left out in the courtyard unattended.</p> <p>During an interview on 9/30/14 at 11:15 a.m., the Dementia Unit Director indicated the Art Therapy Director was assisting people off the unit and the resident was left outside and fell on the cement. He indicated it was an unusual occurrence and was not sure why it was not reported to the State. He indicated staff were not allowed to leave residents outside unattended.</p> <p>The current care plan, dated 8/20/14, indicated Resident (C) had identified problems related to falls, history of falls, pain and osteoporosis. Approaches to the problem included, but were not limited to, "routinely remind resident to ask for assistance when wanting to transfer and assess that wheel chair is of appropriate size; assess need to have wheelchair locked/unlocked for safety and anti-tippers."</p> <p>Review of a current facility policy, dated 1/1/13, titled "Human Resources Management Policies and Procedures Manual", which was provided by the Administrator on 9/29/14 at 11:00 a.m., indicated the following:</p>			

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	<p>"Policy It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source...</p> <p><u>...GOODS AND SERVICES NECESSARY TO AVOID PHYSICAL HARM OR MENTAL SUFFERING:</u> These include, but are not limited to the following: the provision of medical care for physical and mental health needs, assistance in personal hygiene, adequate clothing, adequately heated and ventilated shelter, protection from health and safety hazards...."</p> <p>This Federal tag relates to Complaint IN00156844.</p>						