

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
--	---

(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
F000000	<p>This visit was for the Investigation of Complaints IN00134747 and IN00134907.</p> <p>This visit was in conjunction with the Annual Recertification and State Licensure Survey.</p> <p>Complaint IN00134747 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F314.</p> <p>Complaint IN00134907 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F314.</p> <p>Survey dates: August 19, 20, 21, 22, and 23, 2013</p> <p>Facility number: 000146 Provider number: 155242 AIM number: 100291200</p> <p>Survey Team: Ginger McNamee RN, TC Betty Retherford RN Karen Lewis RN Jason Mench RN Tina Smith-Staats RN</p> <p>Census bed type:</p>	F000000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
--	---

(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>SNF/NF: 127 Total: 127</p> <p>Census payor type: Medicare: 16 Medicaid: 104 Other: 7 Total: 127</p> <p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303		
(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	
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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, record review, and interview, the facility failed to ensure residents with skin impairments were assessed for the possible need for treatment for 2 of 3 residents reviewed for skin assessment of the 3 who met the criteria for non pressure related skin conditions. (Residents #C and #D)</p> <p>Findings include:</p> <p>1.) During an observation on 8/19/13 at 10:13 a.m., a large abraded area (approximately 5 inches by 8 inches and irregular in shape) was noted on the resident's outer lower left leg. The skin was red without drainage. The lower extremities presented with notable edema. The resident was wearing shorts and the area was easily visible. The skin was tight and shinny in appearance. The resident denied pain or discomfort.</p> <p>During an observation on 8/20/13 at 2:00 p.m. the area on the resident's</p>	F000309	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>F-309 Provide Care/Services For Highest well-being 1. Resident C was seen by physician for skin condition and edema of lower left extremity. No new orders were given at time of visit. Skin assessment documentation was implemented. Resident D was seen by Nurse Practioner with new treatment orders given along with skin assessment and documentation by nursing staff. DNS/designee completed individual performance improvement counseling and re-education with the nurse(s) responsible. 2. All residents have the potential to be affected. Thus this plan of correction applies to</p>	09/22/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303			
(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>leg remained as noted previously. The resident was wearing shorts and the area was easily visible.</p> <p>The clinical record for Resident #C was reviewed on 8/21/13 at 8:00 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, recurrent deep vein thrombosis, diabetes, chronic obstructive pulmonary disease, prostate cancer, iron deficiency anemia, arthritis, increased weakness, hyperlipidemia, hypertension, edema, morbid obesity, diabetic neuropathy, and long-anticoagulation therapy.</p> <p>The admission nursing assessment, dated 8/6/13, and subsequent nursing notes through 8/20/13, lacked any information related to the area on the resident's left outer leg.</p> <p>LPN #1 was interviewed on 8/21/13 at 11:00 a.m. LPN #1 indicated she was not aware of the area on the left lower leg of the resident. LPN #1 asked LPN #5 (also working on the unit) if she was aware Resident #C had an area of impaired skin on his outer left leg. LPN #5 indicated she was not aware of this area.</p> <p>2.) During an observation on 8/19/13 at 9:54 a.m., Resident #D was seen</p>		<p>all residents. Administrative nursing/designee completed a facility wide skin sweep to ensure all residents had appropriate skin assessment, treatment and documentation to any skin issues/concerns. 3. Nursing staff have been re-educated by the SDC and DON relative to provision of necessary care and services, including but not limited to existing policy and procedure related to monitoring the wound care management program. 4. A performance improvement tool "Nursing Rounds QA" was implemented to be utilized by the Unit Managers on scheduled days and be ongoing to ensure compliance. The DON or designee will review the findings weekly and shall report to the QAPI committee monthly for 6 months to track and trend outcomes for compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
--	---

(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>up in his geri-chair. A scaly, scabbed area was noted on Resident #D's forehead the approximate size of a quarter. A follow up observation of Resident #D on 8/20/13 at 3:00 p.m. indicated the scaly scabbed area was still present.</p> <p>During a Resident observation on 8/21/13 at 8:00 a.m., the resident was seen lying in bed and a scaly, scabbed area the approximate size of a quarter was noted on Resident #D's forehead. No dressing was present.</p> <p>LPN #5 was interviewed on 8/21/13 at 8:05 a.m. LPN #5 indicated Resident #D had the scaly area on his forehead since she had started working on this unit in the last month. She indicated the other nursing staff had informed her the scaly area on his forehead had been present on admission.</p> <p>The clinical record for Resident #D was reviewed on 8/21/13 at 8:20 a.m.</p> <p>Diagnoses for Resident #D included, but were not limited to, Methicillin-resistant staphylococcus aureus, gastrostomy tube placement, tracheostomy, Parkinson's disease, dementia with Lewy bodies, and acute and chronic respiratory failure.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
--	---

(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>Physician orders, nursing notes, physician progress notes and the physician history and physical lacked any information regarding the scaly, scabbed area on the resident's forehead.</p> <p>LPN #5 was interviewed on 8/21/13 at 3:30 p.m. LPN #5 indicated the Nurse Practitioner was in the building and was going to look at the skin area on Resident #D's forehead. She indicated the Nurse Practitioner was unaware of the condition and could not find any reference to that skin problem by the physician.</p> <p>This federal tag relates to Complaint IN00134907 and IN00134737.</p> <p>3.1-37(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303			
(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			
F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with multiple pressure areas received repositioning services in accordance with his plan of care for 1 of 3 residents reviewed of the 4 who met the criteria for pressure ulcer review. (Resident #B)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 8/19/13 at 10:45 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, history of peritonitis with surgery, cerebrovascular accident, encephalopathy, hypertension and diabetes mellitus type 2. The clinical record indicated the resident had recently had a health decline and was</p>	F000314	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>F314-D TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Resident B is no longer a resident at the facility. DON/designee completed individual performance improvement counseling and re-education done by SDC and DON with the nursing staff responsible. All residents with routine turn schedules have the potential to be affected; thus this plan of correction applied to only</p>	09/22/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303			
(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>now receiving hospice services. He was unable to take food orally and received gastrostomy tube feedings at 40 milliliters an hour.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 7/18/13, indicated Resident #B had severe cognitive impairment and required extensive assistance from the staff for all turning and repositioning services. The assessment indicated the resident had two pressure areas on admission.</p> <p>A health care plan, dated 7/22/13 and last updated on 8/19/13, indicated the resident had a problem with impaired skin integrity related to an abdominal surgical wound, a stage 4 pressure area on the coccyx area, a stage 2 pressure area on both buttocks, and an unstageable area on the right hip. Interventions for the problem included, but were not limited to, "reposition per policy".</p> <p>A pressure ulcer risk assessment, dated 8/14/13, indicated the resident had a score of 9. This indicated the resident was at "very high risk" for pressure ulcers.</p> <p>A physician's order, dated 8/14/13, indicated the resident was to be</p>		<p>those residents. Administrative nursing/designee has completed an initial audit to assure that all residents with routine turn schedules are in compliance. Nursing staff have been re-educated by SDC and DON relative to provision of necessary care and services, including but not limited to existing policy and procedure related to monitoring the turn schedule compliance and wound prevention or worsening. Performance improvement tool "Turn Schedule Tool" was implemented to be utilized by the Unit Manager/Designee on scheduled days and be ongoing to ensure compliance. Performance Improvement tool "Compliance Resident Turn Tool" to be used by staff nurse every shift and turned into the Unit Manager daily. The DON/designee will review the findings weekly and shall report to the QAPI committee monthly for 6 months to track and trend outcomes for compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
--	---

(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>turned "side to side every hour".</p> <p>A nursing note entry, dated 8/19/13 at 6:15 p.m., indicated a new discolored area had been noted on the resident's left hip area. The area was listed as an "unstageable deep tissue injury". The area measured 19.0 centimeters (cm) by 14.0 cm with distinct edges and a clearly visible outline.</p> <p>During observations on the following dates and times, Resident #B was observed for repositioning services.</p> <p>8/21/13 at 8:50 a.m. - Resident #B was observed lying on his back in bed with the head of the bed elevated approximately 45 degrees. The resident's body was tilted slightly to the right. A small pillow was noted to be in place under the left side of the resident's back.</p> <p>8/21/13 at 9:45 a.m. - The resident's body remained in the same position as noted previously. He had moved his head slightly.</p> <p>8/21/13 at 9:57 a.m. - The resident remained in the same position as noted previously.</p> <p>8/21/13 at 10:25 a.m. - The resident remained in the same position as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
--	---

(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>noted previously with the exception of some head movement.</p> <p>8/21/13 at 11:12 a.m.- The resident remained in the same position as noted at 8:50 a.m.</p> <p>8/21/13 at 11:35 a.m.- The resident's body still remained in the same position as noted. The small pillow continues to be in place under the left side of the resident's back. He continued to be tilted to his right. He was noted to have some movement of his head on the pillow.</p> <p>8/21/13 at 11:40 a.m. - LPN #1 and CNA #2 were summoned to the room, removed the pillow from beneath the left side of the resident's back, and used a turn sheet to reposition the resident onto his left side. There were a few grooves noted in the skin on the resident's right hip/buttock/thigh area, but no reddened or open areas were noted.</p> <p>CNA #2 was interviewed on 8/21/13 at 11:40 a.m. CNA #2 indicated he had turned the resident twice since he came in at 6 a.m. He indicated he had turned the resident around 7 a.m. and around 8 a.m. He indicated CNA #4 and CNA #3 (who were on orientation) had been assisting the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303		
(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>resident since that time.</p> <p>CNA #3 came to the door of the resident's room on 8/21/13 at 11:41 a.m. and CNA #2 asked CNA #3 if she and CNA #4 had repositioned the resident. CNA #3 indicated they had been in the room and attempted to readjust the resident, but they had needed more pillows.</p> <p>The DoN and LPN #1 were interviewed on 8/22/13 at 1:00 p.m. Additional information was requested related to the lack of repositioning services for Resident #B. The DoN indicated she had helped CNA #2 reposition the resident earlier that morning and felt certain that the other CNAs had been repositioning him and she would have them talk with me.</p> <p>CNA #4 was interviewed on 8/22/13 at 1:23 p.m. He indicated he and CNA #3 had repositioned and turned the resident toward the wall on his left side around 10 a.m. He said the resident's newest wound was on the resident's right side and they were trying to keep him off of the wound.</p> <p>The newest wound was on the resident's left side and this is the side the resident would have been on if he was turned toward the wall. The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
--	---

(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>resident was not positioned on his left side facing the wall during any of the observations noted above on 8/21/13 from 8:50 a.m. through 11:40 a.m.</p> <p>CNA #3 was interviewed on 8/22/13 at 1:30 p.m. She indicated she and CNA #4 had turned the resident around 9:20 a.m. and he was facing the door which would be his right side. She indicated they turned him again around 10:30 a.m. (more on his back). She indicated they used pillows under him to help relieve pressure, but he was very heavy and it was hard to keep him in position. She indicated they never turned him toward the wall because that was his bad side (the left side with the newest pressure area).</p> <p>The resident was not turned from side to side in accordance with physician's orders during any of the observations noted above on 8/21/13 from 8:50 a.m. through 11:40 a.m.</p> <p>Review of the current facility policy, dated 2011, provided by the Administrator on 8/23/13 at 10:48 a.m., titled "Skin Care and Wound Management Program" included, but was not limited to, the following:</p> <p>"Facility Practice Guidelines:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
--	---

(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>"The facility attempts to prevent resident/patient skin impairment and to promote the fast healing of an existing wound....</p> <p>"Components of the skin care and wound management program include, but are not limited to, the following:</p> <p>Systematic identification of resident/patients at risk for the developing of pressure ulcers</p> <p>Implementation of preventative measures timely to minimize the potential for developing pressure ulcers and skin integrity issues</p> <p>...Application of treatment protocols based on clinical best practice standards for promotion of wound healing."</p> <p>This federal tag relates to Complaint IN00134907 and IN00134737.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			