

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 11/13/2015
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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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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00186407.</p> <p>Complaint IN00186407 - Substantiated. Federal/State deficiencies related to the allegations are cited at F224 and F323.</p> <p>Survey dates: November 12 and 13, 2015</p> <p>Facility number: 000310 Provider number: 155443 AIM number: 100288970</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor type: Medicare: 3 Medicaid: 50 Other: 4 Total: 57</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on November</p>	F 0000	<p>Preparation and/or execution of the plan of correction in general, or this corrective action in particular, does not constitute an admission of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>The Plan of correction is to serve as The Waters of Muncie's credible allegation of compliance.</p> <p>The Waters of Muncie is requesting paper compliance.</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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F 0224 SS=D Bldg. 00	<p>16, 2015.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure residents were free from allegations of verbal abuse for 1 of 5 residents reviewed for abuse in a sample of 5. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 11/12/15 at 11:00 a.m. Diagnoses for Resident D included, but were not limited to, dementia with behavioral disturbances, Parkinsonism, chronic pain, dysphasia and hypertension.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment, dated 9/4/15, was reviewed on 11/12/15 at 11:00 a.m. The MDS indicated Resident D was severely cognitively impaired.</p>	F 0224	<p>It is the practice of The Waters of Muncie to ensure each resident has the right to be free from mistreatment. This finding was related to a self-reported incident. The Waters of Muncie had already implemented a plan of correction prior to the complaint survey. CNA #12 who spoke to Resident D inappropriately is no longer employed at The Waters of Muncie. Resident D is spoken to by staff at all times with respect and dignity as are all of the other residents who reside in the facility.</p> <p>Any residents who were cared for by CNA #12 had the potential to be affected by this finding. Interviews were completed for interviewable residents that had been cared for by CNA #12 and no other residents verbalized concerns.</p>	12/11/2015	

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	<p>Resident D received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 2 person physical assist; dressing, bathing and hygiene- extensive assist with 1 person physical assist; and extensive assist with 2 person physical assist for toilet use. Resident D was assessed as occasionally incontinent of bladder and frequently incontinent of bowel. Resident D had no impairments to range of motion in all extremities.</p> <p>During a review on 11/12/15 at 10:15 a.m., of recent facility reported incidents, an investigative report involving Resident D and a nursing staff Certified Nursing Assistant (CNA) was reviewed. The investigative report indicated that on 10/19/15 the daughter of Resident D brought a concern related to the care given to her mother and the conduct of a nursing staff member. The reportable indicated the following: "CNA [name of CNA] was terminated from employment due to inappropriate response to resident's request for assistance. [Resident's name] daughter was in the resident's room when [CNA's name] said 'you are not my boss' to the resident and then told the resident to tell her (the employee) what her (the employee) name was. [CNA's name] did assist the resident, but her responses were</p>		<p>All staff has been educated and in-serviced on abuse protocol, resident rights and ADL assistance. Social Service Director or designee will randomly select 5 interviewable residents to interview using the Resident Interview and Resident Observation Form (Form CMS-20050). Interviews will be conducted until 4 consecutive weeks of zero negative findings are achieved. Afterwards, interviews will be conducted weekly for a period of not less than 6 months to ensure ongoing compliance. After that, reviews will be random ongoing. Note: Any findings will be addressed/corrected as discovered.</p> <p>Social Service Director or designee will be required to submit Form CMS-20050 to the Quality Assurance Committee who will be responsible for the facilities compliance. Any patterns discovered during the monitoring will be addressed. If necessary, an Action Plan will be written by the committee. The Administrator will monitor the plan weekly until resolution.</p>		

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	<p>inappropriate. [Resident's name] does not recall the event and did not have any physical injury. Follow-up meeting held with [Resident's name] daughter on 10/23/15 to conclude investigation and actions taken. No other residents were found to be affected by employee's actions. All staff are inserviced on Abuse Protocol and staff response(s) to resident(s)."</p> <p>Documentation regarding the family member's allegation of 10/19/15 was not found in the clinical record.</p> <p>During an interview on 11/12/15 at 11:54 a.m. the daughter of Resident D indicated she had come to visit her mother on 10/19/15 at approximately 10:00 a.m. Her mother was still in bed and wearing night clothes. The daughter stated her mother put her call light on and waited approximately 20 minutes before anyone came to answer the call light. She indicated the resident called for help. Staff members could be heard talking in the hallway. The CNA #12 entered the room. Resident D requested assistance to the bath room and CNA #12 responded by telling Resident D she was not her boss. CNA #12 also verbalized comments such as "You can't talk that way to people." Resident D asked CNA #12 to get her wheelchair. CNA #12</p>			

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F 0323 SS=D Bldg. 00	<p>stood in front of Resident D's bed and asked "What's my name?" Resident D was unable to recall the CNA's name and CNA #12 repeatedly asked "What's my name?" before getting the wheelchair and assisting Resident D.</p> <p>During an interview on 11/12/15 at 4:38 p.m., the DON indicated she had seen a video showing inappropriate behavior by CNA #12. The DON indicated the other residents under the care of CNA #12 were interviewed. "This behavior will not be tolerated. We interviewed the other residents and found no complaints of inappropriate behavior. All residents have the right to be free of abuse of any kind."</p> <p>This federal tag relates to Complaint IN00186407.</p> <p>3.1-27 (b)</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</p>						

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	<p>assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure supervision for a severely cognitively impaired resident, living on the locked unit, was provided resulting in an incident of elopement for 1 of 3 residents reviewed. This deficient practice had the potential to effect 12 residents living on the locked unit. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 11/12/15 at 11:18 a.m. Diagnoses for Resident C included, but were not limited to, dementia, anxiety disorder, cognitive deficit following cerebrovascular disease, hypertension, hypothyroidism and aphasia.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment, dated 9/16/15, was reviewed on 11/12/15 at 11:18 a.m. The MDS indicated Resident C was severely cognitively impaired. Resident C received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 1 person physical assist; dressing, bathing and hygiene- extensive assist with 1 person physical assist; extensive assist with 2 person physical assist for toilet use; and supervision of 1 person</p>			F 0323	<p>It is the practice of The Waters of Muncie to provide each resident a safe and secure environment during construction. This finding was related to a self-reported incident. The Waters of Muncie had already completed a root cause analysis and implemented a plan of correction prior to the complaint survey. Resident C was immediately brought back into the building and assessed with no injury. All facility doors were checked and found to be shut and locked.</p> <p>A full head count of residents was completed. No other residents were affected by the open door. Resident C has been and will continue to be kept safe and supervised in the facility.</p> <p>All residents who do not need assistance to ambulate had the potential to be affected by this finding. Maintenance was educated on the need for the secured unit and the safety of the residents. To prevent a reoccurrence, the Maintenance Supervisor will inform the Administrator of any construction projects. The Maintenance Supervisor and Administrator will be responsible for completing a construction project plan prior to start of construction. In the future, no doors will be propped or left open for any amount</p>		12/11/2015

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	<p>physical assist for ambulation. Resident C was assessed as occasionally incontinent of bladder and frequently incontinent of bowel. Resident D had no impairments to range of motion in all extremities. Resident C lives on facility's the locked Alzheimer's unit.</p> <p>During a review on 11/12/15 at 10:15 a.m. of recent facility reported incidents, an reported incident involving Resident C as elopement was reviewed. The investigative report indicated that on 11/2/15 at 3:01 p.m., Resident C was found walking alone outside the facility in the front entrance parking lot. Immediate actions taken included bringing Resident C back into the locked unit by the DON (Director of Nursing). The investigative report indicated a wall was being taken out in the locked unit and the construction workers had left the door to the outside open.</p> <p>On 11/12/15 at 10:45 a.m., the Maintenance Supervisor provided the following written statement: "While removing a wall from the Hope Springs [locked unit] dinning [sic] room, a door was propped open to allow debris to be taken outside and to ventilate the construction area. There were three employees working on the project and at one point two of the employees wanted a</p>		<p>of time without constant supervision. Any staffs who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.</p> <p>The Maintenance Supervisor will notify the Administrator daily at the CQI Meeting of any necessary construction or project plans in resident care areas. The Construction Project Plan Form will be completed for projects in resident care areas and submitted to the Quality Assurance Committee who will review and monitor the Maintenance Supervisor's plans for compliance. Any patterns of concerns relative to construction issues will be reviewed by the committee at the monthly Q. A. Meetings. If necessary, an Action Plan will be written by the committee. The plan will be reviewed weekly by the Administrator until resolution.</p> <p>Note: Any concerns will be addresses as discovered.</p>		

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	<p>drink. The two employees wanting a drink were from the [name of another facility] and did not know where our vending machines were located, so I walked them down to the vending machines. After showing them the vending machine location, I walked back down to the construction area. We failed to shut the doors at the time we left [name of unit]. There were three nursing staff at the nurses station located across from the construction area at the time we left the area."</p> <p>During an interview on 11/12/15 at 2:10 p.m., CNA (Certified Nursing Assistant) #2 indicated the following: "They were tearing down a wall back there. Most of the residents went to the dining room (North dining room off the locked unit), but she (Resident C) wouldn't go. I had her in a chair in front of the shower room where we could keep an eye on her. I got called to go get a resident in the dining room (North dining room) and get a weight. I told the QMA (Qualified Medication Aide) I was leaving and to keep an eye on her (Resident C). By the time I got back, the chair was empty. I asked the QMA where [Resident C's name] was and she said she went back to her room. I started down the hallway to check on her, but another resident called me into their room for help. When I got</p>			

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	<p>done helping the other resident I saw [name of DON] bringing [name of Resident C] back to the unit."</p> <p>During an interview on 11/12/15 at 2:19 p.m., QMA #3 indicated the following: "I was back there with [CNA's name]. [Name of Assistant Director of Nursing] or [name of DON] called for us to get some weights. I couldn't leave because I had a resident acting out and I needed to keep an eye on him. The nurse was on break so it was just me back there. One resident was agitated and it was increasing and he was trying to go help the construction workers. I needed to calm him down. By that time [name of CNA] came back and asked where [Resident C] was. I thought she had gone down the hall. After they brought [Resident C] back, we did a head count and the nurse did a head to toe assessment on [Resident C]." QMA #3 indicated Resident C often walked the hallways on the unit.</p> <p>During an interview on 11/12/15 at 2:45 p.m., LPN #4 indicated the following: "Another resident was agitated so we were walking him around to calm him down. I took him to the dining room (North dining room off the locked unit) and brought him back. The construction noise was over stimulating him. He</p>			

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	<p>calmed down and I went to the bath room. When I came out, I was told [Resident C] had been found in the parking lot (outside). The construction people left the door open and walked away."</p> <p>During an interview on 11/12/15 at 4:38 p.m., the DON indicated the door leading outside the facility on the locked unit should have never been propped open or left open. The DON also indicated all doors on the locked unit should remain closed and locked at all times and the doors are all key coded for exit and entry.</p> <p>Requested elopement risk assessment provided by the DON indicated resident C was an elopement risk. The DON stated all the residents on the locked unit were at risk for elopement.</p> <p>During an interview on 11/13/15 at 11:15 a.m., the Maintenance Supervisor indicated during the construction on the locked unit the door leading outside had been propped open and should have been closed before leaving the unit.</p> <p>This federal tag relates to Complaint IN00186407.</p> <p>3.1-45(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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