STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155549		06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBEND LIVING CENTER	7524 E JACKSON ST MUNCIE, IN 47302

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00173573. Complaint IN00173573 - Substantiated-Federal/State deficiency related to allegations are cited at F224 and F226. Survey date: June 4, 2015 Facility number: 000681 Provider number: 155549 AIM number: 100286100 Census bed type: SNF/NF: 40 Total: 40 Census payor type: Medicare: 4 Medicaid: 33 Other: 3 Total: 40 Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0224	483.13(c)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBEND LIVING CENTER	7524 E JACKSON ST MUNCIE, IN 47302

(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
SS=E Bldg. 00	PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 prevent the mistreatment of residents in regards to personal photos published on a social media website without proper consent for 5 of 5 residents reviewed for mistreatment. (Residents B, C, D, E and F) Findings Include: 1. The clinical record of Resident B was reviewed on 6/4/15 at 2:10 p.m. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, episodic mood disorder and persistent mental disorder. The Annual Minimum Data Set, dated 2/24/15, indicated Resident B was cognitively intact. During an interview on 6/4/15 at 1:00 p.m., Resident B indicated she was aware of social media websites. She indicated she did not want any pictures of herself posted on social media because someone might steal her identify. Review of Resident B's contact sheet, a	F 0224	I. The photos were taken of an activity occurring during national nursing home week. The nurse who posted them on social media did not intend harm to the residents, rather was sharing the success of the event and the apparent resident enjoyment of the event. The nurse has been addressed and re-educated as to the prohibition of posting any resident's photo in any manner and/or on any type of social media without the expressed consent of the resident. Residents B, C, D, E, & F were not negatively impacted and the photos have been removed from the social media website.II. As all residents of the facility could be affected,the following corrective actions have been taken.III. The employee handbook addresses prohibition of use of personal cellphones during working hours, thus prohibiting ability to take photos of residents. All staff will be addressed and re-educated as to this policy, as well as the prohibition of taking a photo and/or posting any resident's photo in any manner and/or on any type of social media without the expressed consent of the	06/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155549		06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBEND LIVING CENTER	7524 E JACKSON ST MUNCIE, IN 47302

(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
	legal guardian had been appointed. The guardian was also the financial representative. A signed Consent Record, dated 4/25/14, indicated Resident B's photo was to be taken for identification and treatment purposes. The authorization for photographs included, during therapy, for medical records and during activities. 2. The clinical record of Resident C was reviewed on 6/4/15 at 12:20 p.m. Diagnoses included, but were not limited to, hypertension, mild mental retardation, depression, schizophrenia, congestive heart failure and dementia. The Quarterly Minimum Data Set, dated 5/14/15, indicated Resident C was severely cognitively impaired and not interviewable. Review of Resident C's contact sheet indicated a legal guardian had been appointed. The guardian was also the financial representative. A signed Consent Record, dated 2/12/15, indicated Resident C's photo was to be taken for identification and treatment purposes. The authorization for photographs included, during therapy, for medical records and during activities.		resident.The facility resident photo consent in use has been reviewed and revised to include the ability to consent to having photos taken during facility events for purposes of posting on facility bulletin boards,calendars, facility website for purposes of marketing, etc. (See Attachment A). Staff has been educated as to the intent of the consent for purposes stated. (See Attachment B). Following education provided, any noncompliance with observance of the employee handbook policy and/or resident consent in regard to photos shall result in disciplinary action up to and including termination, as warranted.IV. As a means of quality assurance, the Administrator shall conduct at least five random staff interviews (See Attachment C) on varied shifts daily on scheduled days of work for two weeks to assess understanding and staff compliance with observance of the employee handbook and adherence with resident consent in regard to photos. Thereafter, five random interviews on varied shifts will be conducted weekly times two weeks, then monthly ongoing. Results of said interviews and any corrective actions taken shall be reported to the QA Committee during quarterly meetings and interview frequency revised as necessary on the basis of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	3. The clinical record of Resident D was reviewed on 6/4/15 at 11:00 a.m. Diagnoses included, but were not limited to, anemia, ischemic heart disease, congestive heart failure, Alzheimer's disease, persistent mental disorder and delusions. The Annual Minimum Data Set, dated 4/13/15, indicated Resident D was severely cognitively impaired and not interviewable. Review of Resident D's contact sheet indicated a family member was appointed Power of Attorney (POA). The POA was also the financial representative. A signed Consent Record, dated 1/28/14, indicated Resident D's photo was to be taken for identification and treatment purposes. The authorization for photographs included, during therapy, for medical records and during activities. 4. The clinical record of Resident E was reviewed on 6/4/15 at 2:20 p.m. Diagnoses included, but were not limited to, hypertension, anemia, heart failure, depression and glaucoma. The Quarterly Minimum Data Set, dated 4/28/15, indicated Resident E was cognitively intact. During an interview on 6/4/15 at 12:50 p.m., Resident E indicated he had heard			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	about social media but was unaware his picture had been posted on any site. Review of Resident E's contact sheet indicated a family member was appointed as POA. A signed Consent Record, dated 3/28/13, indicated Resident E's photo was to be taken for identification and treatment purposes. The authorization for photographs included, during therapy, for medical records and during activities. 5. The clinical record of Resident F was reviewed on 6/4/15 at 2:30 p.m. Diagnoses included, but were not limited to, hypertension, anemia, heart failure, diabetes mellitus and depression. The Significant Change Minimum Data Set, dated 5/13/15, indicated Resident F was cognitively intact. During an interview on 6/4/15 at 12:40 p.m., Resident F indicated she was unaware any pictures of herself had been posted on a social media website. She indicated it was the first she had heard of it. Review of Resident F's contact sheet indicated she was her own decision person.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	On 6/4/15 at 10:00 a.m., the Administrator indicated she was unsure if the facility or corporation had a specific policy related to photos being released on social media websites. She indicated she was aware the Director of Nursing (DON) had posted some pictures of residents on social media. She indicated the Admission Director reviewed the information with the resident and families on admission related to obtaining consents. During an interview at 10:55 a.m., the Admission Director indicated she was unaware of any additional consents for photos to be released on social media. During an interview at 11:06 a.m., the Corporate Nurse indicated she was not contacted prior to the photos being published. During an interview on 6/4/15 at 11:15 a.m., the Director of Nursing indicated pictures had been taken and posted in the past, so she was not concerned with posting the pictures on social media. She indicated all the pictures were taken in a group setting and she did not intend any harm. An interview at 11:30 a.m., the Activity Director indicated during the initial			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	assessment, residents and families were asked if their pictures could be posted throughout the facility, as well as, the local newspaper for breast cancer awareness. The initial Activity Assessment information was obtained from the resident and/or responsible party. A check mark was then placed beside any area the person specified the information not to be released. She indicated she never asked if they could be posted on social media because she did not use social media. During an interview at 11:40 a.m., the Administrator indicated the photos were not taken with a cell phone, but the facility's digital camera. She indicated the facility did not have a policy stating employees could not take pictures of residents, only that they could not use their phones during work hours. On 6/4/15 at 3:10 p.m., the Corporate Nurse indicated Resident F did not have a consent record on file because the Admission Packet had changed after her admission. Review of the facility's Admission Packet, provided by the Administrator on 6/4/15 at 9:40 a.m., indicated a consent record under Miscellaneous, titled "Photo Consent", which indicated the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155549		06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBEND LIVING CENTER	7524 E JACKSON ST MUNCIE, IN 47302

(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
	"...It has been explained, and is understood, that this photograph will be used only as a tool to assist facility staff in resident identification and treatment. It has also been explained that this photograph will become an inclusion in the residents health record. The undersigned has been informed that the use of this photograph for purposes other than those herein stated shall require additional, specific consent of this resident or his authorized representative." This Federal tag related to Complaint IN00173573. 3.1-28(a)			
F 0226 SS=E Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 observation, interview and record review, the facility to develop a policy in regards to employees taking unauthorized photos without proper consent for 5 of 5 residents reviewed for mistreatment. (Residents B, C, D, E and F)	F 0226	I. The photos were taken of an activity occurring during national nursing home week. The nurse who posted them on social media did not intend harm to the residents, rather was sharing the success of the event and the apparent resident enjoyment of the event. The nurse has been	06/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	Findings Include: 1. The clinical record of Resident B was reviewed on 6/4/15 at 2:10 p.m. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, episodic mood disorder and persistent mental disorder. The Annual Minimum Data Set, dated 2/24/15, indicated Resident B was cognitively intact. During an interview on 6/4/15 at 1:00 p.m., Resident B indicated she was aware of social media websites. She indicated she did not want any pictures of herself posted on social media because someone might steal her identify. A signed Consent Record, dated 4/25/14, indicated Resident B's photo was to be taken for identification and treatment purposes. The authorization for photographs included, during therapy, for medical records and during activities. 2. The clinical record of Resident C was reviewed on 6/4/15 at 12:20 p.m. Diagnoses included, but were not limited to, hypertension, mild mental retardation, depression, schizophrenia, congestive heart failure and dementia. The Quarterly Minimum Data Set, dated 5/14/15, indicated Resident C was		addressed and re-educated as to the prohibition of posting any resident's photo in any manner and/or on any type of social media without the expressed consent of the resident. Residents B, C, D, E, & F were not negatively impacted and the photos have been removed from the social media website.II. As all residents of the facility could be affected,the following corrective actions have been taken.III. The employee handbook addresses prohibition of use of personal cellphones during working hours, thus prohibiting ability to take photos of residents. All staff will be addressed and re-educated as to this policy, as well as the prohibition of taking a photo and/or posting any resident's photo in any manner and/or on any type of social media without the expressed consent of the resident.The facility resident photo consent in use has been reviewed and revised to include the ability to consent to having photos taken during facility events for purposes of posting on facility bulletin boards,calendars, facility website for purposes of marketing, etc. (See Attachment A). Staff has been educated as to the intent of the consent for purposes stated. (See Attachment B). Following education provided, any noncompliance with observance of the employee handbook policy and/or resident consent in regard	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	severely cognitively impaired and not interviewable. A signed Consent Record, dated 2/12/15, indicated Resident C's photo was to be taken for identification and treatment purposes. The authorization for photographs included, during therapy, for medical records and during activities. 3. The clinical record of Resident D was reviewed on 6/4/15 at 11:00 a.m. Diagnoses included, but were not limited to, anemia, ischemic heart disease, congestive heart failure, Alzheimer's disease, persistent mental disorder and delusions. The Annual Minimum Data Set dated 4/13/15, indicated Resident D was severely cognitively impaired and not interviewable. A signed Consent Record, dated 1/28/14, indicated Resident D's photo was to be taken for identification and treatment purposes. The authorization for photographs included, during therapy, for medical records and during activities. 4. The clinical record of Resident E was reviewed on 6/4/15 at 2:20 p.m. Diagnoses included, but were not limited to, hypertension, anemia, heart failure, depression and glaucoma. The Quarterly Minimum Data Set, dated 4/28/15,		to photos shall result in disciplinary action up to and including termination, as warranted.IV. As a means of quality assurance, the Administrator shall conduct at least five random staff interviews (See Attachment C) on varied shifts daily on scheduled days of work for two weeks to assess understanding and staff compliance with observance of the employee handbook and adherence with resident consent in regard to photos. Thereafter, five random interviews on varied shifts will be conducted weekly times two weeks, then monthly ongoing. Results of said interviews and any corrective actions taken shall be reported to the QA Committee during quarterly meetings and interview frequency revised as necessary on the basis of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	indicated Resident E was cognitively intact. During an interview on 6/4/15 at 12:50 p.m., Resident E indicated he had heard about social media but was unaware his picture had been posted on any site. A signed Consent Record, dated 3/28/13, indicated Resident E's photo was to be taken for identification and treatment purposes. The authorization for photographs included, during therapy, for medical records and during activities. 5. The clinical record of Resident F was reviewed on 6/4/15 at 2:30 p.m. Diagnoses included, but were not limited to, hypertension, anemia, heart failure, diabetes mellitus and depression. The Significant Change Minimum Data Set, dated 5/13/15, indicated Resident F was cognitively intact. During an interview on 6/4/15 at 12:40 p.m., Resident F indicated she was unaware any pictures of herself had been posted on a social media website. She indicated it was the first she had heard of it. Review of Resident F's contact sheet, indicated she was her own decision person.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	On 6/4/15 at 10:00 a.m., the Administrator indicated she was unsure if the facility or corporation had a specific policy related to photos being released on social media websites. She indicated she was aware the Director of Nursing (DON) had posted some pictures of residents on social media. She indicated the Admission Director reviewed the information with the resident and families on admission related to consents. On 6/4/15 at 10:45 a.m., the Administrator provided a list of residents whose pictures were posted on a social media website. The list contained 26 residents who faces were recognizable on the website. During an interview at 10:55 a.m., the Admission Director indicated she was unaware of any additional consents for photos to be released. During an interview at 11:06 a.m., the Corporate Nurse indicated she was not contacted prior to the photos being published. During an interview on 6/4/15 at 11:15 a.m., the Director of Nursing indicated pictures had been taken and posted in the past, so she was not concerned with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	posting the pictures on social media. She indicated all the pictures were taken in a group setting and she did not intend any harm. During an interview at 11:30 a.m., the Activity Director indicated during the initial assessment, residents and families were asked if their pictures could be posted throughout the facility, as well as, the local newspaper for breast cancer awareness. The initial Activity Assessment information was obtained from the resident and/or responsible party. A check mark was then placed beside any area the person specified the information was not to be released. She indicated she never asked if they could be posted on social media because she did not use social media. During an interview at 11:40 a.m., the Administrator indicated the facility did not have a policy stating employees could not take pictures of residents, only that they could not use their phones during work hours. Review of the facilities Admission Packet, provided by the Administrator on 6/4/15 at 9:40 a.m., indicated a consent record under; Miscellaneous, titled "Photo Consent", indicated the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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
	"...It has been explained, and is understood, that this photograph will be used only as a tool to assist facility staff in resident identification and treatment. It has also been explained that this photograph will become an inclusion in the residents health record. The undersigned has been informed that the use of this photograph for purposes other than those herein stated shall require additional, specific consent of this resident or his authorized representative." An untitled and undated additional policy was provided by the Administrator on 6/4/15 at 11:45 am., indicating the following: "...AA. Personal Equipment Employees are not to use their personal equipment, such as cell phones, PDS's, or pagers during work time.... This prohibition applies to all functions of the cell phone, pager, or other personal equipment including, but not limited to, camera functions, web-browsing, games, audio..." This Federal tag related to Complaint IN00173573. 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302	

(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