

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/08/2016
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NAME OF PROVIDER OR SUPPLIER  WATERS EDGE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00203993.</p> <p>Complaint IN00203993 - Substantiated. Federal/State deficiencies related to allegations are cited at F177 and F250.</p> <p>Survey dates: July 6, 7, and 8, 2016</p> <p>Facility number: 000013 Provider number: 155038 AIM number: 10026100</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicare: 7 Medicaid: 46 Total: 53</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on July 14, 2016.</p>	F 0000		
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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 0177 SS=G Bldg. 00	<p>483.10(o) RIGHT TO REFUSE CERTAIN TRANSFERS</p> <p>An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or a resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.</p> <p>A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.</p> <p>Based on interview and record review, the facility failed to ensure a resident had received the appropriate due process related to a 30 day notice of discharge, resulting in fear of retaliation for 1 of 6 residents reviewed for resident rights (Resident B) and 1 of 3 residents reviewed for discharge. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 7/6/2016 at 11:00 a.m. Diagnoses included, but were not limited to, depressive episodes, anxiety, anorexia and post traumatic stress disorder.</p>	F 0177	<p>Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>F177</p> <ul style="list-style-type: none"> <li>· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</li> <li>· The individual is no longer a resident of Waters Edge Village.</li> <li>· how other residents having the potential to be affected by the</li> </ul>	07/25/2016

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	<p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/19/2016, was reviewed on 7/6/2016 at 11:00 a.m. The MDS indicated Resident B was cognitively intact with a BIMS (Brief Interview for Mental Status Score) of 15 out of 15.</p> <p>Review of the clinical record, on 7/6/2016 at 11:00 a.m., from 8/15/2014 to 6/23/2016, indicated the clinical record lacked any care plan for non compliant behaviors related to smoking or documentation of any prior smoking policy violations.</p> <p>Review of a nursing note, dated 6/12/2016, indicated the following: 6/12/2015 at 8:31 p.m., "res (resident) [sic] was observed with smoking materials in the court yard. the [sic] materials were ceased [sic] and secured."</p> <p>Review of an IDT (interdisciplinary team) note, dated 6/13/2016, indicated the following: 6/13/2016 at 11:55 a.m., " IDT met to review confirmation of resident having possession of inappropriate smoking materials according to sign facility policy via resident. Resident was caught smoking outside with other residents against facility policy. SSD (Social Service Director) and CNA (name of</p>		<p>samedeficient practice will be identified and what corrective action(s) will betaken; All residents discharged from the facilityhave the potential to be affected.</p> <ul style="list-style-type: none"> <li>-An audit has been completed of dischargedresidents for the prior 6 months and no other residents of Waters Edge Villagehave been issued a 30 day involuntary discharge.</li> <li>- what measures will be put into place or what systemic changes willbe made to ensure that the deficient practice does not recur;</li> <li>-All staff involved in the discharge processhave been inserviced on the state guidelines for issuing a 30 day involuntarydischarge as well as the facility policy on involuntary discharge. A dischargecheck off list will be put into place to ensure that all necessary steps arecarried out in the proper order. All potential involuntary discharges will bediscussed by a committee consisting of the Home Office Social ServiceConsultant, Executive Director, Director of Nursing Services, and the facilitysocial service and or Memory care facilitator. Input from the residents PrimaryCare Physician and Psychological Services provider will be sought, but theywill not be required to be in attendance for the meeting. An IDT note will be entered into the</li> </ul>	

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	<p>CNA) searched resident room per policy. SSD, DNS (Director of Nursing Services) and ED (Executive Director) met with resident and made resident aware of safety check. SSD and CNA made resident aware of the finding of cigarettes and lighters. Resident [sic] family made aware via SSD. DNS contacted ombudsman at residents [sic] request. ED issuing [sic] resident 30 day d/c notice facility found. Resident request to d/c to a facility in Muncie, Indianapolis and Bloomington if possible. ED, DNS, UM (Unit Manager), MR (Medical Records), and writer in attendance."</p> <p>Review of a nursing note, dated 6/23/2016, indicated the following: 6/23/2016 at 2:30 p.m., "res [sic] left via facility bus to discharge to another facility. res [sic] took all belongings with her. All medications were sent along with progress notes and lab work and cigarettes. Res [sic] signed discharge papers and copy was sent with her."</p> <p>Review of a "Notice of Transfer or Discharge" form, dated 6/13/2016, indicated a signature by the ED but lacked Resident B's signature. The form indicated Resident B was a danger to the facility.</p> <p>During an interview on 7/6/2016 at 9:33</p>		<p>medicalrecord detailing the findings of the committee. All involuntary discharges will be reviewed by the Home Office SocialService Consultant prior to issuance and weekly until discharge occurs.</p> <ul style="list-style-type: none"> <li>·how the corrective action(s) will be monitored to ensure thedeficient practice will not recur, i.e., what quality assurance program will beput into place; and</li> <li>·To ensure compliance, the ED/Designee isresponsible for completion of the Involuntary Discharge CQI tool when alldischarges occur. Results of the audits will be reviewed by the QAPI committee.If 100% compliance is not achieved, an action plan will be developed. 100 %review will be implemented for the next 6 months.</li> <li>·by what date the systemic changes will be completed. 7/25/16</li> </ul>		

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	<p>a.m., the Ombudsman indicated she had been called to the facility at the request of Resident B. The Ombudsman's investigation concluded Resident B had no prior documented events related to smoking policy violations. The Ombudsman indicated Resident B feared retribution in the form of withheld medications if an appeal to the Notice of Transfer was initiated. The Ombudsman indicated in her interviews with the SSD (Social Service Director), the SSD indicated to her Resident B was not a danger to the facility. The Ombudsman indicated in her interview with the ED (Executive Director), the ED indicated the facility might be discharging "many people who don't fit into (name of parent company) model - dementia diagnosis".</p> <p>During an interview on 7/6/2016 at 1:18 p.m., the SSD denied making a statement to the Ombudsman indicating Resident B was not a danger to the facility.</p> <p>During an interview on 7/7/2016 at 12:12 p.m., the ED indicated he had given Resident B the 30 day Notice of Discharge letter after she had been found in violation of the smoking policy. The ED denied making a statement to the Ombudsman regarding the discharge of residents with a diagnosis of dementia.</p>			

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F 0250 SS=D Bldg. 00	<p>During an interview on 7/8/2016 at 8:20 a.m., Resident B verbalized a fear of having the anti anxiety medications held if an appeal was initiated. "I was wanting to appeal it until they started taking my Klonopin (anti-anxiety medication). I didn't want to leave. That place was my home and I had friends there - like family. I told (name of Ombudsman) they were taking my medicines from me. I can't have that! I need my anxiety medicine! I knew about the appeal because I read it. No one told me about it." Resident B became visibly upset and tearful during this interview.</p> <p>This federal tag relates to Complaints IN00203993.</p> <p>3.1-12(a)(7)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to develop a plan of care to ensure the resident was offered services to assist with non compliant behaviors related to the smoking policy.</p>	F 0250	Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies".	07/25/2016

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	<p>This deficient practice effected 1 of 3 residents reviewed. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 7/6/2016 at 11:00 a.m. Diagnoses included, but were not limited to, depressive episodes, anxiety, anorexia and post traumatic stress disorder.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/19/2016, was reviewed on 7/6/2016 at 11:00 a.m. The MDS indicated Resident B was cognitively intact with a BIMS (Brief Interview for Mental Status Score) of 15 out of 15.</p> <p>Review of the clinical record on 7/6/2016 at 11:00 a.m., from 8/15/2014 to 6/23/2016, indicated the clinical record lacked any care plan for non compliant behaviors related to smoking or documentation of any prior smoking policy violations.</p> <p>During an interview on 7/7/2016 at 9:46 a.m., the DON (Director of Nursing) indicated Resident B had a history of non compliance with the facility smoking policy. "She, at several times, would have cigarettes on her person that she</p>		<p>This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>F250</p> <ul style="list-style-type: none"> <li>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</li> <li>The individual is no longer a resident of Waters Edge Village.</li> <li>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</li> </ul> <p>All residents who smoke have the potential to be affected. A Care Plan audit as well as a smoking assessment audit was conducted of all residents who smoke was conducted by the Social Services Director and Memory Care Facilitator. The last six months of new and worsening behavior events have been reviewed to identify residents for non compliance with the facility smoking policy. The Care plans of all residents that were identified as being non compliance were reviewed and updated.</p> <ul style="list-style-type: none"> <li>what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</li> <li>All residents found to be non compliant with smoking will be</li> </ul>	

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	<p>would turn over voluntarily or if we noticed them." The DON indicated she was not aware of any history of Resident B having cigarette lighters in the past.</p> <p>During an interview on 7/7/2016 at 1:18 p.m., the SSD (Social Service Director) indicated Resident B had a history of non compliance with the facility smoking policy. The SSD acknowledged there was no care plan or behavior management process in place to assist Resident B with this alleged behavior. The SSD indicated there should have been a care plan and a behavior management process in place to assist Resident B with these behaviors.</p> <p>This federal tag relates to Complaints IN00203993.</p> <p>3.1-34(a)</p>		<p>brought through IDT meeting for review on the next business day. A New smoking assessment will be completed, a care plan for non-compliance will be initiated and a behavioral flow sheet will be initiated for monitoring. The resident will be provided re-education on the smoking policy and on safety, and offered alternatives to tobacco usagesuch as cessation and/or use of electronic cigarettes. Care plans related tosmoking will be reviewed every month via behavior meeting as well as behaviorflow sheets. Nurses have been inserviced on initiated newand worsening behavior events for non compliance with the facility smokingpolicy by the Facility Social Services Director. New and worsening behaviorswill be reviewed at the next morning meeting following the event and reviewedby the IDT</p> <p>how the corrective action(s) will be monitored to ensure thedeficient practice will not recur, i.e., what quality assurance program will beput into place; and All new and worsening behaviors related to smokingnon compliance as well as the associated careplan and behavior flow sheet willbe brought to the monthly QAPI meeting for review. The Items will be reviewedfor accuracy and completeness by</p>				

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			the Executive Director. All discrepancies will be immediately corrected and re-education/disciplinary action will be provided as needed. Action plans will be developed as discrepancies occur. The process will continue until the facility is discrepancy free for 6 consecutive months. by what date the systemic changes will be completed. 7/25/16		