

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 01/05/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
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F000000	<p>This visit was for the Investigation of Complaint IN00160523.</p> <p>Complaint IN00160523 Substantiated. Federal/State deficiencies related to the allegations are cited at F312 and F514.</p> <p>Survey dates: January 2 and 5, 2015</p> <p>Facility number: 000146 Provider number: 155242 AIM number: 100291200</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 119 Total: 119</p> <p>Census payor type: Medicare: 29 Medicaid: 79 Other: 11 Total: 119</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p>	F000000	<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. Supporting documents are included with the submission of this plan of correction. The facility respectfully requests a desk review for paper compliance of these deficiencies</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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F000312 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure residents were provided with nail care and oral hygiene as indicated in their plan of care for 3 of 4 residents reviewed for assistance with activities of daily living in a sample of 4. (Resident #'s B, C, and D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #D was reviewed on 1/2/15 at 11:45 a.m. Diagnoses for the resident included, but were not limited to, anoxic encephalopathy, seizure disorder, aphasia, and diabetes mellitus.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 12/26/14, indicated Resident #D was severely cognitively impaired and was totally dependent on</p>	F000312	<p>This Plan of Correction is thecenter's credible allegation of compliance.</p> <p>Preparation and/or execution of thisplan of correction does not constitute admission or agreement by the providerof the truth of the facts alleged or conclusions set forth in the statement ofdeficiencies. The plan of correction isprepared and/or executed solely because it is required by the provisions offederal and state law.</p> <p>F312 It is the practice of the facility toprovide for dependent residents care needed to maintain grooming, personal andoral hygiene.</p> <p>1.Residents #D had nail care completedon 1/2/15. Resident # C oral care completed after lunch on 1/2/15 asplanned per resident</p>	01/26/2015

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	<p>the staff for all activities of daily living.</p> <p>A health care plan problem, last reviewed on 10/9/14, indicated the resident was totally dependent on the staff for all activities of daily living. One of the approaches for this problem was "Nail care prn [as needed]".</p> <p>The shower records for the resident, dated from 11/1/14 through 12/31/14, contained a section for the documentation of whether nail care had been given during part of the shower/bathing process. The records were marked "no" and/or were blank in the section designated for the staff to document that nail care had been provided for the months of November and December 2014.</p> <p>During an observation on 1/2/15 at 9:18 a.m., conducted with LPN #1, Resident #D was resting in bed. The resident's hands were both curled inward. When the hands were opened with the assistance of LPN #1, the resident's fingernails were noted to be long and irregular in shape. No sores were noted on the palms of the resident's hands, but the end of her left thumb was noted to be dark and discolored in appearance.</p> <p>LPN #2 was interviewed on 1/2/15 at</p>		<p>request. Resident #B no longer resides in the facility.</p> <p>2.All residents have the potential to be affected. Nail care was administered to all dependent residents as a baseline for the implementation of a new QA monitoring system on 1/5/15. Resident # C was interviewed in regards to preference in regards to time for oral care completed. Again, resident requested no morning oral care but, after lunch and before bedtime. Request will continue to be honored. No further dependent residents were found to be affected in regards to oral care.</p> <p>3.All nursing staff has been re-inserviced on facility policies regarding nail care, oral care and revised documentation system.</p> <p>4.Unit Managers and ADNS will monitor Kiosk/Point of Care reports where oral care is now being documented as being completed by CNA's for each dependent resident. System will be monitored 5 times a week during clinical start-up, ongoing to ensure compliance. Nail care will continue to be</p>				

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	<p>12:25 p.m. She indicated Resident #D had a history of cellulitis of the left thumb which had caused the discoloration of that area. She indicated the thumb nail area had bled that morning when the residents hands were cleansed and a treatment had been obtained from the physician.</p> <p>2. The clinical record for Resident #B was reviewed on 1/2/15 at 2 p.m. Diagnoses for the resident included, but were not limited to, microcephalus, moderate mental retardation, and seizure disorder.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 10/13/14, indicated Resident #B was severely cognitively impaired and was totally dependent on the staff for all activities of daily living.</p> <p>A health care plan problem, dated 10/24/14, indicated the resident was totally dependent on the staff for all activities of daily living. One of the approaches for this problem was "Nail care prn [as needed]".</p> <p>The shower records for the resident, dated from 11/1/14 through her transfer to the hospital on 12/2/14, contained a section for the documentation of whether</p>		<p>monitored by Unit Managers and ADNS via shower sheets and newlyimplemented QA tracking tool. (Exhibit 1 and 2). DNS will be responsible for reporting compliance to the QACommittee monthly times three and quarterly, thereafter.</p>		

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	<p>nail care had been given during part of the shower/bathing process. The records were marked "no" and/or were blank in the section designated for the staff to document that nail care had been provided during that time period.</p> <p>The clinical record lacked any documentation of nail care having been provided to the resident from 11/1/14 through her 12/2/14 transfer to the hospital.</p> <p>The DON was interviewed on 1/5/14 at 2 p.m. She indicated she was unable to provide documentation of nail care having been provided to Resident #B during the time period noted.</p> <p>3. Review of the current facility policy, revised October 2010, provided by the Administrator on 1/5/15 at 1 p.m., titled "Care of Fingernails/Toenails", included, but was not limited to, the following:</p> <p>"Purpose The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.</p> <p>Preparation 1. Review the resident's care plan to assess for any special needs of the resident....</p>						

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	<p>General Guidelines</p> <p>1. Nail care includes daily cleaning and regular trimming....</p> <p>Reporting</p> <p>1. Notify the supervisor if the resident refuses the care.</p> <p>2. Report other information in accordance with facility policy and professional standards of practice."</p> <p>4. The clinical record for Resident #C was reviewed on 1/2/15 at 10:25 a.m. Diagnoses for the resident included, but were not limited to, multiple sclerosis, Parkinson's disease, and paralysis.</p> <p>A significant change MDS assessment, dated 12/11/14, indicated Resident #C had no cognitive impairment, but required extensive assistance from the staff for all activities of daily living.</p> <p>A health care plan problem, dated 11/17/14, indicated the resident needed the assistance of the staff for all activities of daily living. One of the approaches for this problem was "Oral care twice daily and prn [as needed]".</p> <p>A health care plan problem, dated 11/17/14, indicated Resident #C was at risk for dental/mouth problems related to</p>			

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	<p>having her own teeth with some decays in her teeth per dental notes. One of the approaches for this problem was "Provide oral care daily and as needed".</p> <p>During an observation, conducted with LPN #1 on 1/2/15 at 9:25 a.m., Resident #C was resting in her bed. Some yellowish debris was noted in the resident's mouth. The resident indicated her teeth had not been brushed that morning. She indicated her teeth were not brushed every day. She indicated they had been brushed "last night", but had not been done for several days prior to that. She indicated she would sometimes ask the staff to brush her teeth and they indicated they would return later to do it, but then their shift would be over without the assistance having been given. Resident #C indicated she had talked to the Administrator about this problem recently at the Christmas Party and it had gotten better for several days, but the problem had recurred.</p> <p>The Administrator was interviewed on 1/2/15 at 9:45 a.m. He indicated he did remember talking to Resident #C in the past regarding oral care, but did not think it had been at the Christmas Party. He indicated the resident had a history of refusing oral care at times.</p>			

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	<p>The clinical record lacked any documentation of refusals of oral care for the months of December 2014 and/or January 2015.</p> <p>The DON was interviewed on 1/5/15 at 2 p.m. She indicated "personal hygiene" was documented in the kiosk system (computer system) by the CNAs on a shift by shift basis, but the system did not have any separate method to identify that oral care had been given as part of the personal hygiene provided.</p> <p>5. Review of the current facility policy, revised October 2010, provided by the Administrator on 1/5/15 at 1 p.m., titled "Mouth Care", included, but was not limited to, the following:</p> <p>"Purpose The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth.</p> <p>Preparation 1. Review the resident's care plan to assess for any special needs of the resident...</p> <p>Documentation The following information should be</p>			

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F000514 SS=D	<p>recorded in the resident's medical record:</p> <p>1. The date and time the mouth care was provided. The name and title of the individual(s) who provided the mouth care....</p> <p>3. If the resident refused the treatment, the reason(s) why and the intervention taken....</p> <p>Reporting</p> <p>1. Notifying the supervisor if the resident refuses the mouth care...."</p> <p>This federal tag relates to Complaint IN00160523.</p> <p>3.1-38(a)(3)(C) 3.1-38(a)(3)(E)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>				

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	<p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented for 1 of 2 residents reviewed for documentation of feeding tube replacement in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 1/2/15 at 2 p.m. Diagnoses for the resident included, but were not limited to, microcephalus, moderate mental retardation, and seizure disorder.</p> <p>A signed recapitulation (recap) of physician's orders, dated 11/18/14, indicated Resident B received nutritional feedings per a jejunostomy tube (J-tube). The recap included an order which indicated "May change J-tube size 20 French as needed". The original date of this order was 2/12/14.</p> <p>A physician's order, dated 10/15/14, indicated "Change g-tube [gastrostomy tube] d/t [due to] unable to flush/clogged."</p> <p>A nursing note entry, dated 10/15/14 at 2:15 p.m., included, but was not limited to, the following:</p>	F000514	<p>F514</p> <p>It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented.</p> <p>1. Resident #B no longer resides in the facility.</p> <p>2. All residents have the potential to be affected. An audit on all residents with feeding tubes was completed to ensure physician's orders were complete with tube size indicated. No other residents were identified as being affected.</p> <p>III/IV. All licensed staff will be re-instructed on acceptable practice for writing complete physician's telephone orders and documenting nursing procedures in the clinical record.</p> <p>All telephone orders and nursing notes for a 24 hour period will be reviewed daily during clinical start-up to ensure accuracy. M-F the review will be completed by unit managers, ADNS or DNS. Saturday and Sunday by weekend nurse manager.</p> <p>Clinical start-up audits will be daily ongoing utilizing a QA tool. (Exhibit 3).</p> <p>The DNS will report findings of the audits to the QA committee monthly, times three and quarterly, thereafter.</p>	01/26/2015			

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	<p>"Res is fully dependent on staff for all ADL's [activities of daily living].... Res has g-tube for nutrition and meds. Changed today per writer. No issues...."</p> <p>The nursing note lacked any information related to why the physician was contacted when an order for changing the J-tube was already in place and/or what size of tube was reanchored when the tube was changed.</p> <p>The DON was interviewed on 1/5/14 at 1:45 p.m. She indicated she had no information to provide related to what size of feeding tube had been reanchored on 10/15/14 or why the physician had been contacted when an order was already in place.</p> <p>2. Review of the current facility policy, revised April 2008, provided by the Administrator on 1/5/14 at 1 p.m., titled "Charting and Documentation", included, but was not limited to, the following:</p> <p>"Policy Statement All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record....</p> <p>Documentation Criteria 6. Documentation of a procedures and</p>			

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	<p>treatments shall include care-specific details and shall include at a minimum:</p> <p>a. The date and time of the procedure/treatment was provided.</p> <p>...c. The assessment data and/or any unusual findings obtained during the procedure/treatment;</p> <p>d. How the resident tolerated the procedure/treatment...."</p> <p>This federal tag relates to Complaint IN00160523.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				