STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155229	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/29/2011
NAME OF PROVIDER OR SUPPLIER WOODLANDS THE		STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST MUNCIE, IN47304	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for the Investigation of Complaint IN00099922. Complaint IN00099922 - Substantiated. Federal/state deficiencies related to the allegation are cited at F282 and F514. Survey dates: November 28, 29, 2011 Facility number: 000134 Provider number:155229 AIM number: 100275430 Surveyor: Jeri Curtis, RN Census bed type: SNF/NF: 89 Total: 89 Census payor type: Medicare: 5 Medicaid: 74 Other: 10 Total: 89 Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 12/01/11 by Suzanne	F0000		

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.

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F0282 SS=D	Williams, RN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, the facility failed to assure the application of a skin ointment was applied to an abrasion on the hip, as ordered by the physician and in accordance with the plan of care, for 1 (Resident A) of 3 residents reviewed for following the plan of care in a sample of 4. Findings include: The record of Resident (A) was reviewed on 11/28/11, at 2:40 P.M., and indicated diagnoses including dementia, diabetes, and coronary artery disease. An 11/7/11, order by the physician indicated Santyl was to be applied to an area on the left hip daily. The treatment record indicated the Santyl application to the left hip was not started until 11/9/11. The 11/7/11, plan of care indicated a concern of an area to the left hip with a goal of healing without infection by 12/7/11. An intervention included completing treatment as ordered by the physician. The facility's revised 10/7/10, Pressure	F0282	F 282 Services by qualified persons/plan of care 1.The delay in treatment for Resident A with the new medication occurred because family had requested to supply the ordered medication. Treatment was immediately started when medication was delivered by family. 2.Residents with family members providing medications have the potential to be affected. Residents with family members providing medications will have medications reviewed by the Director of Nursing or the Executive Director on 12/13/11 to confirm that medications have been received timely. Untimely medications will be obtained per facility if needed. 3.New medication orders will be reviewed by Nursing Management in morning meeting Monday thru Friday. Residents who have family members providing medications will be identified and receipt of the medication verified by the Unit Manager assigned to that Unit. 4.The Director of Nursing or designee will audit 5 resident charts to ensure timely arrival of family supplied medications weekly times 4 weeks, every 2 weeks times 4 weeks, monthly	12/16/2011

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	Ulcer Policy, Evaluations, Screenings, and Assessments, was provided by the Director of Nursing (DoN), 11/28/11. The policy criteria indicated lesions that are present or which develop subsequently to admission, were to be treated according to medical direction, and conscientiously followed. This federal tag relates to Complaint IN00099922. 3.1-35(g)(2)		times 4 months and then quarterly until 100% compliance is attained and maintained times 2 quarters. 5.Completion Date 12/16/11	
F0514 SS=D	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. 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. Based on record review and interview, the facility failed to ensure a skin assessment was accurately documented for 1 (Resident A) of 3 residents among the sample of 4 reviewed for documentation of skin assessments. Findings include: The record of Resident (A) was reviewed	F0514	F 514 Records Complete/Accurate 1.The area on Resident A was assessed by the Wound Nurse on 11/7/11 and a new treatment obtained for the abrasion. On 11/10/11 the Wound Nurse completed her weekly wound rounds and documented her narrative assessment at that time. 2.Residents with open areas have the potential to be affected.	12/16/2011

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	11/28/11, at 2:40 P.M. The 11/6/11, 5:00 A.M., nursing note documented by Licensed Practical Nurse (LPN #1) indicated 3 pressure areas to the left hip, reddish purple in color, with measurements of (A) 1 by 1.1 centimeters (cm), (B) 2 by 2.1 cm, and (C) 4 by .8 cm. The next documentation of the area to the left hip was on 11/10/11, at 4:01 P.M., by the ADoN, indicating an improved abrasion measuring 7.8 by 6.2, and will continue to monitor. The ADoN was interviewed at 3:10 P.M., 11/28/11, after reviewing the 11/6, and 11/10/11, nursing note documentation of an assessment of the left hip. The ADoN indicated a discrepancy. The ADoN indicated she had received notification of the area to the left hip of Resident (A) on 11/9/11. The ADoN indicated she had investigated the cause of the abrasion and found Resident (A) did not have a cushion in the wheel chair seat. The ADoN indicated 3 bolts holding the sea frame had rubbed against the skin, causing the abrasion. The ADoN indicated her assessment indicated Resident (A) had a large abrasion and LPN #1 should not have documented the area as pressure ulcers. LPN #1 was interviewed by telephone		Nursing documentation for residents with open areas have been audited to ensure that Nursing Assessments are accurate. 3.Nurses were educated 12/13/11 by the S.D.C. to proper procedure for documenting new open areas. Residents identified with skin integrity concerns or with new orders for skin treatments will be reviewed during morning stand-up meeting Monday thru Friday with follow-up assessment and documentation by the Wound Nurse as needed. 4.The Director of Nursing or designee will audit Nursing Notes, orders and skin assessments for residents with new open areas to ensure that accurate documentation is in place weekly times 4 weeks, every 2 weeks times 4 weeks, monthly times 4 months and then quarterly until 100% compliance is attained and maintained times 2 quarters. 5.Completion Date 12/16/11	

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	11/29/11, and indicated when she had done the assessment of Resident (A) on 11/6/11, she was unsure if the area was a pressure ulcer or an abrasion. LPN #1 indicated there was no depth to the area. The facility's revised 10/7/10, Pressure Ulcer Policy, Evaluations, Screenings, and Assessments, was provided by the Director of Nursing (DoN), 11/28/11. The pre-admission and post admission weekly guidelines indicated the assessment required an adequate description of the skin condition. This federal tag relates to Complaint IN00099922. 3.1-50(a)(2)			