STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MUNCIE	2701 LYN-MAR DR MUNCIE, IN 47304

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00205578. Complaint IN00205578 - Substantiated. Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226. Survey dates: July 21-22, 2016 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census bed type: SNF/NF: 92 Total: 92 Census payor type: Medicare: 6 Medicaid: 82 Other: 4 Total: 92 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	This plan of correction constitutes the facility's written allegation of compliance; however, the plan is not an admission that a deficiency existed or that one was cited correctly The plan of correction is being submitted to meet the requirements of state and federal law	

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

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	QR completed on July 25, 2016 by 17934.			
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of			

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	law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on observation, record review, and interview, the facility failed to ensure an injury of unknown origin was reported in 1 of 4 residents reviewed for accidents and falls. (Resident C) Findings include: The clinical record for Resident C was reviewed on 7/21/2016 at 1:15 p.m.	F 0225	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident C no longer resides in the facility. ADNS was made aware of Resident C's bruise of unknown origin on 7/21/16. An immediate investigation was implemented and reported per company policy. 2) How other residents having the potential	08/21/2016

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	Diagnoses included, but were not limited to alcohol cirrhosis of the liver with ascites, hypertension, diabetes type 2, chronic obstructive pulmonary disease, congestive heart failure and major depressive disorder. During an observation on 7/21/2016 at 8:21 a.m., Resident C was observed lying on one of two mattress on the floor in the resident's room. Resident C was noted to have a large bruise on the left shoulder. The bruise was dark purple with yellow areas noted at the edges. The bruise measured 8 cm x 7 cm. Resident C was also noted to have multiple scabbed areas on the arms and legs. During an observation with the ADNS (Assistant Director of Nursing Services) on 7/21/2016 at 3:39 p.m., Resident C's left shoulder bruise was discussed. The ADNS denied any knowledge of the bruise. Review of the "Admission Clinical Health Status" dated 7/13/2016, lacked any documentation of a bruise on the left shoulder of Resident C. Review of the admission nursing noted dated 7/13/2016 at 4:15 p.m. read as follows: "Res (resident) arrived per (name of ambulance company) for (name		to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All nursing staff will be in-serviced related to reporting injuries of unknown origin per company policy. The abuse policy was reviewed with all nursing staff. Nurse #8 was educated related to reporting injuries of unknown origin and following company policy for documentation. Skin assessments on every resident in the building were completed to identify any injuries of unknown origin. No other residents were found to be affected. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DNS or designee will complete skin audits 5 times weekly for one month, 4 times weekly for one month, 3 times weekly for one month, 2 times weekly for one month, and once weekly for 2 months to ensure that any injury of unknown origin was identified, and company policy is followed ensuring that no injuries were missed 4) How the corrective action will monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? Audit results will be forwarded to the QAPI Committee each month for 6 months to track for trends If any trends are identified in QAPI then audits will be conducted per	

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	of hospital). res [sic] nonsensical at this tie. opens [sic] eyes to touch. Resp (respirations) slow and even, non labored. lung [sic] diminished in bases. bowel[sic] sounds present and abd (abdomen) distended and soft. skin warm and dry. bruising [sic] noted to abd from old pericentsis [sic] site measuring 33 cm x 12 cm. dark purple with no redness or warmth noted. rt [sic] (right) thigh bruising noted to upper thigh measuring 7 cm x 4 cm light purple with no redness or warmth. rt [sic] knee with scab abrasion measuring 2 cm x 2 cm. no redness, warmth or drainage noted. right [sic] ankle with scab noted measuring 0.5 cm x 0.5 cm. no [sic] redness or warmth noted. left [sic] shin with scab measuring 1.0 cm x 0.5 cm, no redness warmth or drainage [sic] right [sic] shoulder with scab abrasion measuring 4 cm x 3 cm , no redness warmth or drainage noted. Left elbow with skin tear measuring 1 cm x 1 cm, no redness or drainage noted, left wrist with skin tear measuring 1.5 cm x 1.0 cm. feet [sic] warm and pedal pulses present. family [sic] at bed side and DNR code status signed. medications [sic] reviewed with (name of nurse), Hospice nurse and md [sic]. no [sic] s/s (signs or symptoms) of pain or discomfort noted at this time. Vs: 120/74, 97.8, 112, 18, 93% [sic]"		QAPI Committee recommendations If there are no trends identified the review this item will be reviewed on a prn basis	

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	Review of the "Weekly Skin Review" dated 7/20/2016, indicated Resident C's skin was intact. No bruising of scabbed areas were noted. Review of the nursing notes dated 7/13/2016 through 7/21/2016 lacked any documentation of Resident C having a bruise on the left shoulder or of Resident C having any falls or accidents throughout the admission. During an interview on 7/22/2016 at 8:39, CNA #7 indicated she had provided care for Resident C on 7/16-17/2016. CNA #7 denied ever seeing a bruise on Resident C's left shoulder. During an interview on 7/22/2016 at 8:46 a.m., LPN #8 indicated she had seen the bruise on Resident C's left shoulder however, LPN #8 could not remember when she first noticed the bruising but indicated it was before 7/21/2016. During an interview on 7/22/2016 at 9:05 a.m., the ADNS indicated the first time she had been made aware of the brushing on Resident C's left shoulder was during the observation with the surveyor on 7/21/2016. The ADNS indicated all skin impairments should be reported and documented. "If a CNA discovers it, it should be reported to the nurse. The			

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	nurse should then assess the area, notify the MD and family. They would then notify myself, the DON (Director of Nursing) and the Administrator. We would investigate to see if we could determine the cause. If we could not determined the cause we would do a State Reportable." The ADNS also indicated "When I was made aware of the bruise, (Name of nurse) measured it and initiated an incident report. The MD was made aware and of course the family knew. They took him (Resident C) yesterday evening. I initiated a State Reportable as well. I will continue the investigation to try to figure out when and how it happened." The ADNS indicated the facility did not follow their policy on injuries of unknown origin and the nursing staff did not follow the assessment policy. During an interview on 7/22/2016 at 10:11 a.m., the Executive Director indicated the facility reports all injuries of unknown origin. "If we would have been aware of it we would have reported it immediately. As soon as it was identified yesterday we reported it." The ED indicated the nursing staff failed to identify and report the bruise on Resident C's left shoulder. Review of a current policy dated			

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	1/13/2016, titled "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation", indicated the following: "Policy Statement: It is the responsibility of all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect [sic] injuries of unknown source and misappropriation of resident property. ... It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect abuse, injuries of unknown source and misappropriation of resident property ("alleged violation") are reported immediately to the Executive Director or Director of Nursing of the Living Center. Such violations are also reported to state agencies in accordance with existing state law. The center investigates each such alleged violation thoroughly and reports the result of all investigations to the executive director [sic] or his or her designee, as well as to state agencies as required by state and federal law. ..." This federal tag relates to Complaint IN00205578. 3.1-28(c)			

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F 0226 SS=D 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 failed to implement their policy related to injuries of unknown origin for 1 of 4 residents review for falls and accidents. (Residents C) Findings Include: The clinical record for Resident C was reviewed on 7/21/2016 at 1:15 p.m. Diagnoses included, but were not limited to alcohol cirrhosis of the liver with ascites, hypertension, diabetes type 2, chronic obstructive pulmonary disease, congestive heart failure and major depressive disorder. During an observation on 7/21/2016 at 8:21 a.m., Resident C was observed lying on one of two mattress on the floor in the resident's room. Resident C was noted to	F 0226	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident C no longer resides in the facility. ADNS was made aware of Resident C's bruise of unknown origin on 7/21/16. An immediate investigation was implemented and reported per company policy. 2) 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? All nursing staff will be in-serviced related to reporting injuries of unknown origin per company policy. The abuse policy was reviewed with all nursing staff. Nurse #8 was educated related to reporting injuries of unknown origin and following company policy for documentation. Skin assessments on every resident in the building were completed to	08/21/2016

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	have a large bruise on the left shoulder. The bruise was dark purple with some yellow areas noted at the edges. The bruise measured 8 cm x 7 cm. During an observation with the ADNS (Assistant Director of Nursing) on 7/21/2016 at 3:39 p.m., Resident C's left shoulder bruise was discussed. The ADNS denied any knowledge of the bruise. Review of the "Admission Clinical Health Status" dated 7/13/2016, lacked any documentation of a bruise on the Resident C's left shoulder. Review of the admission nursing noted dated 7/13/2016 at 4:15 p.m. read as follows: "Res (resident) arrived per (name of ambulance company) for (name of hospital). res [sic] nonsensical at this tie. opens [sic] eyes to touch. Resp (respirations) slow and even, non labored. lung [sic] diminished in bases. bowel[sic] sounds present and abd (abdomen) distended and soft. skin warm and dry. bruising [sic] noted to abd from old pericentsis [sic] site measuring 33 cm x 12 cm. dark purple with no redness or warmth noted. rt [sic] (right) thigh bruising noted to upper thigh measuring 7 cm x 4 cm light purple with no redness or warmth. rt [sic] knee with		identify any injuries of unknown origin. No other residents were found to be affected. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DNS or designee will complete skin audits 5 times weekly for one month, 4 times weekly for one month, 3 times weekly for one month, 2 times weekly for one month, and once weekly for 2 months to ensure that any injury of unknown origin was identified, and company policy is followed ensuring that no injuries were missed 4) How the corrective action will monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? Audit results will be forwarded to the QAPI Committee each month for 6 months to track for trends If any trends are identified in QAPI then audits will be conducted per QAPI Committee recommendations If there are no trends identified the review this item will be reviewed on a prn basis	

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	scab abrasion measuring 2 cm x 2 cm. no redness, warmth or drainage noted. right [sic] ankle with scab noted measuring 0.5 cm x 0.5 cm. no [sic] redness or warmth noted. left [sic] shin with scab measuring 1.0 cm x 0.5 cm, no redness warmth or drainage [sic] right [sic] shoulder with scab abrasion measuring 4 cm x 3 cm , no redness warmth or drainage noted. Left elbow with skin tear measuring 1 cm x 1 cm, no redness or drainage noted, left wrist with skin tear measuring 1.5 cm x 1.0 cm. feet [sic] warm and pedal pulses present. family [sic] at bed side and DNR code status signed. medications [sic] reviewed with (name of nurse), Hospice nurse and md [sic]. no [sic] s/s (signs or symptoms) of pain or discomfort noted at this time. Vs: 120/74, 97.8, 112, 18, 93% [sic]" Review of the "Weekly Skin Review" dated 7/20/2016 indicated Resident C's skin was intact. No bruising of scabbed areas were noted. Review of the nursing notes dated 7/13/2016 through 7/21/2016 lacked any documentation of Resident C having a bruise on the left shoulder or of Resident C having any falls or accidents through that time period. During an interview on 7/21/2016 at 3:00			

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	p.m., the ADNS (Assistant Director of Nursing Services) indicated the skin assessment dated 7/20/2016 was not correct. "If the skin assessment was done correctly it should have had all the skin impairments on it." During an interview on 7/22/2016 at 8:39, CNA #7 indicated she had provided care for Resident C on 7/16-17/2016. CNA #7 denied ever seeing a bruise on Resident C's left shoulder. During an interview on 7/22/2016 at 8:46 a.m., LPN #8 indicated she had seen the bruise on Resident C's left shoulder but could not remember when she first noticed the bruising but indicated it was before 7/21/2016. During an interview on 7/22/2016 at 9:05 a.m., the ADNS indicated the first time she had been made aware of the brushing on Resident C's left shoulder was during the observation with the surveyor on 7/21/2016. The ADNS indicated all skin impairments should be reported and documented. "If a CNA discovers it, it should be reported to the nurse. The nurse should then assess the area, notify the MD and family. They would then notify myself, the DON (Director of Nursing) and the Administrator. We would investigate to see if we could			

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	determine the cause. If we could not determined the cause we would do a State Reportable." The ADNS also indicated "When I was made aware of the bruise, (Name of nurse) measured it and initiated an incident report. The MD was made aware and of course the family knew. They took him (Resident C) yesterday evening. I initiated a State Reportable as well. I will continue the investigation to try to figure out when and how it happened." The ADNS indicated the facility did not follow their policy on injuries of unknown origin and the nursing staff did not follow the assessment policy. During an interview on 7/22/2016 at 10:11 a.m., the Executive Director indicated the facility reports all injuries of unknown origin. "If we would have been aware of it we would have reported it immediately. As soon as it was identified yesterday we reported it." The ED indicated the nursing staff failed to identify and report the bruise on Resident C's left shoulder. Review of a current policy dated 1/13/2016, titled "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation", indicated the following: "Policy Statement: It is the responsibility			

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	of all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect [sic] injuries of unknown source and misappropriation of resident property. ... It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect abuse, injuries of unknown source and misappropriation of resident property ("alleged violation") are reported immediately to the Executive Director or Director of Nursing of the Living Center. Such violations are also reported to state agencies in accordance with existing state law. The center investigates each such alleged violation thoroughly and reports the result of all investigations to the executive director [sic] or his or her designee, as well as to state agencies as required by state and federal law. ..." This Federal tag relates to Complaint IN00205578. 3.1-28(a)			