STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155242	A. BUILDING 00 B. WING	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent a fall resulting in bruising for a dependent resident for 1 of 3 residents reviewed for falls. (Resident 56) Finding includes: During an interview, at the time of an observation on 12/14/22 at 2:50 p.m., Resident 56 was seated in her wheelchair in her room. A greenish-purple discoloration was on the residents left forehead, near the hairline, approximately the size of a half-dollar coin. The resident indicated the bruise was from a fall she had in the shower room a few days ago. A staff member had assisted her off of the toilet, and did not have another staff member to assist her. Her glasses had been broken during the fall as well. She had fallen more than once, when the facility failed to use two staff members for her transfers according to her plan. She never tried to stand on her own and would called for assistance with transfers because she was paralyzed on her left side from a stroke. She was completely aware she was unable to stand without staff assistance. Resident 56's clinical record was reviewed on 12/16/22 at 4:20 p.m. Diagnoses included, but	F 0689	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The Interdisciplinary Team has completed a review of Resident 56's fall prevention interventions to validate appropriate interventions are currently in place to reduce falls. The care plan has been reviewed to ensure the most current fall interventions are in place and staff has been educated on those interventions. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** A one-time review of current resident population for fall interventions has been completed by the IDT to validate residents have appropriate fall interventions in place to mitigate falls. A one-time review of care plans for	01/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ben Wells	Administrator	01/06/2023

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	were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, history of falls, need for assistance with personal care, unspecified pain, and hypertension. Review of a Fall Risk Assessment, dated 11/28/22, indicated the resident lacked any cognition issues and was at high risk for falls. Current medications included the following: hydrocodone-acetaminophen (narcotic pain medication) 5-325 milligrams (mg) tablet four times daily as needed, furosemide (blood pressure/diuretic) 40 mg once daily and amlodipine (blood pressure) 10 mg once daily. A 11/27/22, annual, Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. She required extensive assistance of two staff members for bed mobility, transfers, and toileting. She had frequent urinary and bowel incontinence. She had one fall without injury and one fall with injury since her prior MDS assessment. A current care plan for falls, dated 11/25/19, indicated the resident was at risk for falls related to impaired balance, history of falls, weakness, incontinence, medication use, hemiparesis, and cerebrovascular accident. Interventions included staff to stay with resident during toileting, staff education on not leaving resident in bathroom, and two person assistance for safe transfers. Review of an Event Report, completed on 12/16/22 at 10:49 a.m. for an event date 10/28/22 at 8:40 a.m., indicated the resident was lowered to the floor in the shower room with one witness present.		current resident population for fall prevention interventions has been completed by the IDT to validate residents have appropriate fall interventions in place. Facility staff have been re-educated on root cause analysis of falls, complete investigation process, appropriate fall interventions, and providing updated education on changes to fall prevention intervention(s) for staff providing care and services to residents. **3. What measures will be put in place and what systematic changes will be made to ensure the deficient practice does not recur:** It is the responsibility of the facility staff to implement and validate new fall prevention interventions are in place to mitigate falls. The Director of Nursing, Assistant Director of Nursing, or designee will be responsible to review falls, should they occur, 5 times a week for 2 weeks, weekly for 4 weeks, and then monthly for 3 months to validate revised fall prevention interventions have been identified and implemented for residents who have fallen. Any issues identified will be immediately corrected, 1:1 re-education completed for stakeholder as identified, up to and including disciplinary action as determined necessary by the Administrator and Director of Nursing. **4. How the corrective action**	

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	Review of an Event Report, dated 11/26/22 at 8:04 p.m., indicated the resident had an assisted fall without injury in the shower room with one witness present. The immediate intervention indicated an assist if two with transfers. This intervention had previously been initiated on 1/27/22. Review of an Event Report, dated 12/10/22 at 1:45 p.m., indicated the resident was lowered to the floor in the shower room with an injury to her forehead. One staff member witnessed the fall. The immediate intervention was for the Certified Nurse's Aide (CNA) to remain in the restroom with the resident. This intervention had previously been initiated on 7/16/20. A Nurse's Note, dated 12/10/22 at 2:15 p.m., indicated the resident was in the shower room on the commode when the CNA entered the room and saw the resident attempted to stand. The CNA used the gait belt and lowered the resident to the floor, which resulted in a discoloration to the left forehead. During an interview, on 12/19/22 at 12:03 p.m., CNA 5 indicated the CNAs referenced the CNA Assignment Sheet for any resident specific activity of daily living requirements. The Care Guide for the 100 Unit, provided by CNA 5 at the time of the interview, included the resident was left side affected, required 2 staff members for assistance, and was not to be left in the bathroom unattended. During an interview, on 12/19/22 at 12:18 p.m., CNA 4 indicated Resident 56 had always been cooperative with staff assistance for transfers. The resident had a recent fall which resulted in a bruise on the left side of her face. The resident		**will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** The Administrator or designee will review the audits completed on a weekly basis. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly for 3 months, and then quarterly for 3 quarters. Audit documentation will continue to be submitted to the QAPI committee for review and to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	

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	required a two person assistance for transfers, a gait belt, proper body mechanics, and verbal instructions to the resident of the steps to take during each transfer. The resident had required 2 person staff assistance for transfers for quite awhile prior to her recent fall. During an interview, on 12/20/22 at 10:46 a.m., CNA 6 indicated the resident had a fall where she assisted the resident to the floor using a gait belt on 12/10/22. She had not provided care for this resident prior to 12/10/22. CNA 6 had been charting at the Nurse's Station when the call light activated for the shower room. She answered the call light within 3 minutes and found the resident had been left in the shower room, without monitoring, by another staff member. The resident attempted to stand unaccompanied as she entered the shower room, so she used the gait belt and lowered her to the floor in a prone position. The resident hit her head on the floor and broke her glasses. During a review of the 12/10/22 fall investigation, on 12/20/21 at 11:16 a.m., the documentation indicated the resident was left in the shower room on the commode instead of remaining with the resident. Further documentation was not provided. During an interview, on 12/20/22 at 1:38 p.m., the Interim Director of Nursing (DON) indicated the resident had falls on 10/28/22, 11/26/22 and 12/10/22 where she had been assisted to the floor in the shower room. During an interview, on 12/20/22 at 1:48 p.m., the Corporate Nurse Consultant indicated the resident should not have been left on the commode without monitoring on 12/10/22, as the care plan			

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	indicated staff should have remained with the resident. Review of a current facility policy titled "Falls Policy," provided by the Corporate Nurse Consultant on 12/20/22 at 2:54 p.m., indicated the following: "...POLICY STATEMENT... The intent of this policy is to ensure the facility provides an environment that is free from accident hazards over which the facility has control to prevent avoidable falls. GUIDELINE: ...1. All residents will have a comprehensive fall risk assessment on admission/readmission, quarterly, annually and with significant change of condition. Appropriate care plan interventions will be implemented and evaluated...." 3.1-45(a)			
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;			

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	§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, interview, and record review, the facility failed to offer preferred foods and serve foods prepared in a manner preferred by residents for 2 of 4 residents reviewed for food (Residents 90 and 91) and failed to provide serving sizes and supplemental foods as ordered by the medical provider for 3 of 7 residents reviewed for nutrition. (Residents 42, 45, and 77) Findings include: 1. During an interview, on 12/14/22 at 11:38 a.m., Resident 91 indicated the food was not appetizing. The chef salad listed as an alternative meal item lacked eggs and many times, any meat. She ordered a chef salad last week which had lettuce, a few shaved carrots, a small amount of shredded cheese, and three cherry tomatoes. The kitchen staff had told her they had no meat or eggs for the chef salad. She did not order breakfast foods anymore because she did not like what was served. She ordered milk, juice, and coffee each morning. Her preference for breakfast was fried eggs and toast. The facility did not serve any fresh fruits, cottage cheese, or offer lemonade to drink. Her family and friends brought her fresh fruit and V8 juice. 2. During a meal observation, on 12/20/22 at 9:12 a.m., Resident 90 was eating breakfast. His tray had a bowl of oatmeal, one biscuit with jelly, a small amount of scrambled eggs, a cup of apple	F 0803	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Residents 90 and 91 have been reassessed for food choices/preferences. Residents 42, 45 and 77 have had their diets reviewed by the medical provider. The dietary order and care plans have been updated to reflect the current status of the residents. Dietary staff have been trained on following preferences / choices and medical providers orders. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** A one-time review of current resident population has been completed to review current resident choices/preferences and ordered serving sizes / supplements. The Dietary staff have been provided re-education on honoring resident choice and preference and following serving	01/10/2023

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	juice, and coffee. During an interview, at the time of the observation, he indicated he had not received orange juice this morning. The facility had not taken orders for breakfast, but had occasionally taken orders for lunch and dinner. He disliked the scrambled eggs, but ate them. He preferred his eggs were fried and the facility would offer meat at breakfast. He had requested fried eggs, but was told by staff the facility did not offer fresh eggs. He also preferred toast in the morning. Occasionally, the facility served a sausage patty and piece of bacon, but not often. A current physician's order, dated 12/8/22, indicated the resident was to have a regular diet with special instructions to serve two eggs at breakfast and vitamin C juice at breakfast and dinner. A health care plan, revised 12/16/22, indicated potential for nutrition risk related to history of mild depletion of protein stores and history of weight loss with a decrease in appetite. An approach, dated 6/10/22, indicated the registered dietitian recommended to add vitamin C juice at breakfast and dinner to enhance iron absorption and add an extra egg at breakfast to enhance protein stores. 3. The clinical record for Resident 42 was reviewed on 12/19/22 at 12:47 p.m. Diagnosis included Lewy Body dementia. A health care plan, updated 4/12/18, indicated the resident's family was concerned the resident was not getting enough to eat and requested double portions at all meals. An intervention indicated the resident was to receive double portions with breakfast and lunch, and snacks per resident and resident family wishes.		size / supplemental orders. **3. What measures will be put in place and what systematic changes will be made to ensure the deficient practice does not recur:** It is the responsibility of the dietary staff to provide common food choices and to follow medical providers orders. The Dietary Manager, or designee will audit meals served of a random 10% of the resident population's choices/preferences and medical provider orders 5 times a week for 2 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed for stakeholders as identified, up to and including disciplinary action as determined necessary by the Administrator and Director of Nursing. **4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** The Dietary manager will submit audit findings to Administrator or designee on a weekly basis. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly for 3 months, and then quarterly for 3 quarters. Audit	

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	During a dining observation on 12/20/22 at 11:30 a.m., Resident 42 was observed seated in the dining room with a divided plate. The resident had a single, small scoop serving of ground Swedish meatballs, egg noodles, canned peaches, and a bread roll. During a kitchen observation, on 12/20/22 at 11:00 a.m., Dietary Aide 10 was observed scooping egg noodles and three meatballs onto warmed plates. When preparing a plate for a resident whose meal ticket indicated "double entree," she placed the single serving of three meatballs onto the plate. During an interview, at the time of the observation, Dietary Aide 10 indicated she should have served six meatballs for the double entree. 4. The clinical record for Resident 45 was reviewed on 12/15/22 at 3:11 p.m. Diagnoses included osteoporosis with current pathological fracture and diabetes mellitus-type II. A current physician's order, dated 6/22/22, indicated the resident was to have a regular diet with cottage cheese at lunch and a health shake at all meals. A current health care plan, edited 11/22/22, indicated the resident had an open area on her nose. Approaches included to provide diet as ordered and observe nutritional status and dietary needs. A current health care plan, edited 11/22/22, indicated the resident had potential for nutritional risk related to a diagnoses of diabetes mellitus, history of refusals of care and supplements, wounds, unavoidable weight loss, and poor oral food and fluid intakes.		documentation will continue to be submitted to the QAPI committee for review and to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.	

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	During a meal observation, on 12/16/22 at 11:55 a.m., the resident's lunch tray lacked a serving of cottage cheese. During an interview, at the time of the observation, the resident indicated she had not received cottage cheese on her tray for a long time and she liked cottage cheese. During a meal observation, on 12/19/22 at 12:32 p.m., the resident's lunch tray lacked a serving of cottage cheese. During an interview on 12/19/22 at 2:00 p.m., the District Dietary Manager indicated she was unaware of Resident 45's order for cottage cheese at lunch. She knew there used to be one, but thought it had been changed to a house shake. The dietician had to substitute for the cottage cheese supplement, because the contract did not provide cottage cheese. The contracted provider did not check with the resident about the substitution. 5. Resident 77's clinical record was reviewed on 12/16/22 at 10:19 a.m. Diagnoses included dietary counseling and surveillance, osteoporosis, and vitamin deficiency. A current physician's order, dated 10/21/22, indicated the resident was to have a two gram sodium diet with vitamin C juice and double protein servings with meals. A current health care plan, edited 12/19/22, indicated the resident was at nutritional risk related to diagnoses of congestive heart failure and refusal of concentrated protein supplement. An approach indicated to serve diet per order. During a meal observation, on 12/19/22 at 12:10			

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	p.m., the resident's lunch tray had one hot dog, a fruit cup, and milk. During an interview, on 12/19/22 at 2:14 p.m., the Dietary Manager indicated she performed a food preference assessment with new admissions. The staff had a monthly food meeting with the residents. If the residents requested to add fried eggs to the menu, she would explain they are not available. The dietary department did not serve cottage cheese, lemonade, hot chocolate, fresh fruit, except bananas, or fresh eggs. During a phone interview, on 12/19/22 at 2:28 p.m., the Regional Dietary Manager, indicated the resident preferences were tracked in a system. The dietary provider made reasonable accommodations for resident preferences. They did their best regarding what was included on the menu. Not all facilities had the same food formulary and it depended on the number of residents who wanted a particular service. The facility was the resident's home and the preferences would be accommodated. Fresh eggs, cottage cheese, hot chocolate, lemonade, and fresh fruit were not included in the facilities' food formulary. During an interview, on 12/19/22 at 2:41 p.m., the Administrator indicated the facility tried to accommodate the resident preferences when available. He felt the choice issue was an isolated situation. Review of a current, undated facility policy titled "Indiana and Federal Resident Rights," provided by the Administrator on 12/19/22 at 4:19 p.m., indicated the following: "...Self-Determination...The resident has the right to, and the facility must promote and facilitate			

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	resident self-determination through support of resident choice...." 3.1-21(a)(3)			