STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155549	A. BUILDING 00 B. WING	08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWBEND LIVING CENTER	7524 E JACKSON ST MUNCIE, IN 47302

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 26, 27, 28 & 29, 2022 and August 1, 2022 Facility number: 000681 Provider number: 155549 AIM number: 100286100 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicare: 4 Medicaid: 29 Other: 3 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 8, 2022.	F 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an			

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

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	environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interview, the facility failed to ensure a resident was assisted with a meal in a dignified manner for 1 of 1 residents reviewed for dignity. (Resident 138) Findings include: During an observation of meal service on 7/28/22	F 0550	1. Resident 138 was not negatively affected by this alleged deficient practice. Nursing staff, including LPN 4, have been educated on providing meals in a dignified manner. Resident 138 is receiving meal assistance in a dignified manner. 2. All residents requiring intake	08/09/2022

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	at 11:40 a.m., LPN 4 was observed assisting Resident 138 to eat. LPN 4 stood to the right of the resident, providing bites to resident who lifted her head upwards to consume food. Resident 138's clinical record was reviewed on 7/28/22 at 2:15 p.m. Diagnoses included, but were not limited to, weakness, dementia without behavioral disturbance, and epilepsy. A resident care sheet, provided by LPN 5 on 7/29/22 at 1:58 p.m., indicated Resident 138 required a mechanical soft diet. During an interview on 7/28/22 at 11:45 a.m., after LPN 4 obtained a chair and sat down on the resident's right side, she indicated it was okay to feed a resident while standing. During an interview on 7/28/22 at 11:58 a.m., the Administrator indicated resident's should not be assisted to eat while standing. A Licensed Nurse Job Description, provided by the Administrator on 8/1/22 at 10:56 a.m., included, but was not limited to, "Essential Job Functions:...3. Help to maintain the self respect, personal dignity and physical safety of each resident." A Licensed Nurse Orientation Checklist for LPN 4, dated 12/1/21, provided by the Administrator on 8/1/22 at 10:56 a.m., included, but was not limited to, "Areas of Orientation...Resident Meal Time." The "Instructed and Voiced Understanding" column was initial as completed on 12/1/21. A current facility policy, dated 10/2014, titled, "Feeding Residents," provided by the Administrator on 7/28/22 at 1:48 p.m., included,		assistance have the potential to be affected. Nursing staff, including LPN 4, have been educated on providing meals in a dignified manner. All residents needing meal assistance are receiving it in a dignified manner. 3. The facility's policy for Resident Rights has been reviewed and no changes are indicated at this time. The nursing staff, including LPN 4, has been educated on Resident Rights with a special focus on providing meal assist in a dignified manner. A monitoring tool has been implemented. 4. The DON or designee will be responsible for monitoring meal times and ensuring residents are being assisted with meal intake in a dignified manner. The meal time monitoring will occur on scheduled work days at alternating meal times with the DON/designee monitoring one meal service as follows: daily for two weeks, weekly for six weeks, monthly for three months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted if indicated by increasing or decreasing the monitoring until 100% compliance is obtained. ="" p="">	

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	but was not limited to, the following: "PROCEDURE:...6. Sit on unaffected side, eye level with resident, facing them." 3.1-3(t)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation , interview and record review, the facility failed to prevent resident to resident abuse in a dependent resident, for 1 of 5 residents reviewed for accidents. (Resident 7) Findings include: During an observation on 7/26/22 at 2:51 p.m., Resident 7 sat on a chair in the lounge on the memory care unit and repetitively wrapped a blanket around her baby doll. During an attempted interview at the time of observation on 7/28/22 at 9:24 a.m., the resident	F 0600	1. Resident 7 resides on the secured dementia care unit of the facility. Resident 7 had no long term effects as evidenced by no mental anguish or recollection of events. Resident 7's plan of care has been reviewed and new interventions implemented as indicated in an attempt to prevent further abuse. 2. Other dependent residents have the potential to be affected. Any occurrence will be analyzed and root cause determined, as possible, to assure the plan of care is reviewed and	08/09/2022

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	was not interviewable. She was unable to state her name when asked and propelled herself with her feet about the memory care unit in her wheelchair. As she propelled in her wheelchair, she kissed her baby doll and spoke to the baby doll in incomprehensible words. During an interview on 7/28/22 at 9:58 a.m., Certified Nurse's Aide (CNA) 6 indicated she was familiar with the care of Resident 7 and she was one of the residents with advanced cognitive impairment related to her diagnoses. She was made aware of a resident to resident altercation between Resident 7 and another resident on 6/3/22 and staff were not required to keep Resident 7 away from any other residents. She was unaware of previous altercations. The perpetrator no longer resided at the facility. During an interview on 7/28/22 at 10:02 a.m., the Administrator indicated Resident 7 was the victim during the resident altercation on 6/3/22. The perpetrator was discharged to another facility after the incident occurred for the residents' safety. On 7/28/22 at 10:25 a.m., a review of the facility reported resident to resident altercation on 6/3/22, indicated the following: "evening CNA stated she heard yelling from a room. When she walked out to hallway she saw res [resident 7] being hit by another resident. Res [Resident 7] then hit back until they were broken up. Both residents have no injuries." During an interview on 7/28/22 at 2:07 p.m., Registered Nurse (RN) 7 indicated she was familiar with the residents' care on the memory care unit and the resident to resident altercation on 6/3/22. Resident 7 ambulated anywhere in her wheelchair		updated with new interventions as applicable to prevent further occurrences, as possible. 3. The facility's policy for "Abuse, Prohibition, Reporting and Interventions" was reviewed and no changes are indicated at this time. Staff were re-educated on the abuse policy with special attention to assuring that any occurrence is analyzed and appropriate changes/interventions are made and care plans updated as indicated and shared with staff, to prevent further occurrences. A monitoring tool has been implemented. 4. The Administrator and/or designee will be responsible to monitor behavior memos daily on scheduled work days, to assure it was analyzed by the IDT at next meeting, changes made/interventions updated as appropriate, and care plans updated as indicated, with new interventions communicated to staff. Monitoring will be completed daily, ongoing on scheduled days of work. In addition to this, three residents will be interviewed by the Administrator or designee to ensure abuse is not occurring. These interviews will occur on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for three months, then quarterly thereafter. Should a concern be found, immediate corrective action will	

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	and the perpetrator got agitated if Resident 7 bumped into her while she moved about in her wheelchair on the memory care unit. On 6/3/22, the evening CNA reported to RN 7 she heard yelling from a room and when she walked out to the hallway, the perpetrator hit Resident 7 and Resident 7 hit the perpetrator back. Resident 7 was known to show some aggression with staff during staff care and lacked understanding. Resident 7's clinical record review was completed on 7/28/22 at 2:23 p.m. Diagnoses included, but were not limited to the following: Alzheimer's disease with late onset, age related physical debility, dementia in other diseases classified elsewhere with behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition and major depressive disorder. Medications included, but were not limited to, Aricept (Alzheimer's disease management) 10 milligrams by mouth daily for dementia with behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 4/29/22, indicated the resident had severe cognitive impairment. She required extensive assistance to total dependence on staff for bed mobility, transfers, locomotion on unit, dressing, eating, toileting, personal hygiene, and bathing. A resident to resident altercation care plan indicated the resident had altercations on 3/27/22, 4/1/22 and 6/3/22. Interventions included, but were not limited to, separate the residents if applicable, place resident on 15 minute checks to ensure safety or one-to-ones as needed, as directed by immediate supervisor on duty, provide		occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted if indicated by increasing or decreasing the monitoring until 100% compliance is obtained.	

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	activity of choice and interest to direct attention such as section was left blank. A care plan for verbal behavioral symptoms directed towards others such as: threatening others, screaming at others, and cursing at others, was last updated on 6/7/22. Interventions included, but were not limited to the following: attempt to identify the immediate causal factor or event that precipitates the behavior, remove the resident or other from the area as appropriate or necessary, attempt to use diversion, distraction, and reorientation to calm the resident such as a quiet environment. Review of a Mood and Behavior Communication Memo, dated 3/27/22, indicated the resident was slapped by another resident. Review of a Mood and Behavior Communication Memo, dated 4/1/22, indicated the resident was slapped by another resident. A Nurse's Note, dated 6/3/22 at 4:30 p.m., indicated the resident sat in the hallway and was hit by another resident. The clinical record lacked further Nurse's notes related to altercations. During an interview on 7/28/22 at 2:42 p.m., the Administrator indicated on the following dates, the same perpetrator slapped Resident 7: 3/27/22, 4/1/22, and 6/3/22. After the resident to resident altercation on 6/3/22, the perpetrator was sent out to behavioral health. During an interview on 7/28/22 at 3:17 p.m., the Administrator indicated the perpetrator, in the 3 above mentioned resident to resident altercations, returned to the facility on 6/16/22 and was discharged to another health care facility on			

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	7/14/22. During an interview on 7/28/22 at 4:35 p.m., the Administrator indicated when a resident slapped another resident there was potential for the resident to receive injuries but no injuries were found. A request was made for any progress notes related to the resident to resident altercations on 3/27/22 and 4/1/22. Additional nursing notes were not provided. During an interview on 7/29/22 at 9:26 a.m., the MDS Coordinator indicated abuse included, but was not limited to, resident to resident or staff to resident physical abuse. A resident to resident altercation that did not result in physical injuries would still be considered abuse. During an interview on 7/29/22 at 10:32 a.m., RN 7 indicated abuse included, but was not limited to, physical abuse between a staff to a resident or physical abuse between a resident to a resident. It was still classified as abuse when there is physical abuse between 2 residents even if injuries were not identified. During an interview on 8/1/22 at 1:30 p.m., the Administrator indicated he did not have any further documents regarding the resident to resident altercations on 3/27/22 and 4/1/22. Further documentation was not provided. A current policy, titled "ABUSE PROHIBITION, REPORTING AND INVESTIGATION," provided by the Administrator on 7/29/22 at 11:30 a.m., indicated the following: " POLICY: This facility shall prohibit and prevent abuse, neglect, misappropriation of resident property, and exploitation....Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or			

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	punishment with resulting physical harm, pain or mental anguish...Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...." 3.1-27(a)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure staff were trained on the proper technique when administering insulin from an insulin pen for 1 of 1 residents observed for insulin administration. (Resident 16) Findings include: During observation of medication administration for Resident 16 on 7/29/22 at 8:51 a.m., LPN 5 administered insulin per physician order using a Levemir FlexTouch insulin pen. LPN 5 dialed the pen dose to "10" and administered into resident's abdomen. She did not prime the new needle applied to the insulin pen. Review of resident's clinical record was completed on 7/29/22 at 2:42 p.m. Diagnoses included, but	F 0684	1. Resident 16 was not negatively affected by this alleged deficient practice. Nurses and QMAs including LPN 5 have been educated on proper technique when administering insulin from an insulin pen. Resident 16 is receiving insulin via proper technique. 2. All residents receiving insulin via an insulin pen have the potential to be affected. Nurses and QMAs including LPN 5 have been educated on proper technique when administering insulin from an insulin pen. All residents receiving insulin via an insulin pen are receiving via proper technique.	08/09/2022

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	were not limited to, diabetes mellitus-type II, and diabetic neuropathy. Current physician's orders included, but were not limited to, Levemir FlexTouch, inject 10 units two times a day. The order date was unreadable on document provided. During an interview on 7/29/22 at 9:05 a.m., LPN 4 indicated she should have primed the new needle prior to administration. She indicated the procedure was to dial the dose to one unit and press the administration button. During an interview on 8/1/22 at 2:33 p.m., the Director of Nursing (DON) indicated the nurse should have primed the insulin needle for the Levemir FlexTouch prior to administering insulin. Review of the manufacturer guidelines for the Levemir FlexTouch Pen, provided by the DON on 8/1/22 at 2:40 p.m., indicated the following: "Priming your Levemir FlexTouch Pen:...Step 7: Turn the dose elector to select 2 units...Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top...Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. A drop of insulin should be seen at the needle tip...If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times." 3.1-37(a)		3. The manufacturer's instructions for administering insulin via an insulin pen have been reviewed. Nurses and QMAs including LPN have been educated on the manufacturer's instructions with a special focus on priming the insulin pen prior to drawing up the ordered insulin for the resident. A monitoring tool has been implemented. ="" span="">	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

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	§483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure dairy products were disposed of on the expiration date to avoid resident consumption of expired or contaminated food. Findings include: During a kitchen observation on 7/26/22 at 10:42 a.m., the walk-in refrigerator contained an opened gallon jug of 2% white milk with a use by date of 7/11/22. The jug of white milk was just under half full. It was not dated when the jug was opened. Another opened gallon jug of 2 % white milk, with a use by date of 7/24/22, was in the walk-in cooler on the shelf next to the previously mentioned jug. It contained a quarter of the milk in the jug. It was not dated when the jug was opened. Both of the jugs were beyond the expiration date. The walk-in	F 0812	1 & 2. There were no residents affected by this alleged deficient practice but all residents receiving milk at meal times have the potential to be affected. All expired milk was thrown away on July 26. Dietary staff including Cook 10 and the Dietary Manager have been re-educated on dating items when opened and disposing of items when they expire. 3. The facility's policy for Storage Guidelines for Refrigerator/Freezer/Dry Storeroom has been reviewed and no changes are indicated at this time. The Dietary staff including	08/09/2022

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	refrigerator also contained 14 unopened jugs of 2% white milk that were expired. The walk-in refrigerator did not contain any gallon jugs of white milk that were not expired. During an observation at the time of interview on 7/26/22 at 10:47 a.m., Cook 10 indicated both opened gallon jugs of 2% white milk were expired on 7/11/22 and 7/24/22. She was unable to determine when each of the expired jugs were last used. Milk products should have been disposed of when the product expired but dietary staff did not discard the milk. She disposed of the opened gallon jugs of expired milk at this time but 14 unopened gallons of expired 2 % milk remained in the walk-in refrigerator and were available for use. The walk-in refrigerator did not contain any gallon jugs of 2% white milk that were not expired. During an interview at the time of observation on 7/26/22 at 11:02 a.m., Cook 10 indicated 11 unopened gallons of expired white milk, dated 7/24/22, remained in the walk-in refrigerator. She also had 3 unopened gallons of expired white milk, dated 7/11/22, that remained in the walk-in refrigerator and should not have been available for use. During an interview on 7/27/22 at 8:59 a.m., the Dietary Manager indicated expired products were required to be disposed of on the expiration date by the dietary aides. Expired dietary items should have been overseen by the Dietary Manager as well and had not been completed. A current document, titled "Storage Guidelines for Refrigerator/Freezer/Dry Storeroom," provided by the Administrator on 7/27/22 at 11:21 a.m., indicated the following: "...If product is unopened, please follow use by date as stated on		Cook 10 and the Dietary Manager have been re-educated on this policy with a special focus on dating items when opened and disposing of items when they expire. A monitoring tool has been implemented. 4. The Dietary Manager or designee will be responsible for completing the monitoring tool to ensure items are dated when opened and expired products are disposed of in a timely manner. These observations will be completed on scheduled work days as follows: Daily on an ongoing basis.Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted if indicated by increasing or decreasing the monitoring until 100% compliance is obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155549	A. BUILDING 00 B. WING	08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	package... PRODUCT... Fluid Milk... OPENED... 7 days... COMMENTS... Always discard by use by date on product..." 3.1-21(i)(1) 3.1-21(i)(3)			