

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	---	---------------	---	----------------------

F 0000 Bldg. 00	<p>This visit was for Investigation of Complaints IN00320334, IN00335293, IN00339997, and IN00341421. This visit included a COVID-19 Focused Infection Control Survey.</p> <p>Complaint IN00320334 - Substantiated. Federal/State deficiencies related to the allegation are cited at F684.</p> <p>Complaint IN00335293 - Substantiated. Federal/State deficiencies related to the allegation are cited at F684.</p> <p>Complaint IN00339997 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00341421 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 22 & 23, 2021</p> <p>Facility number: 000310 Provider number: 155443 AIM number: 100288970</p> <p>Census Bed Type: SNF/NF: 29 Total: 29</p> <p>Census Payor Type: Medicare: 11 Medicaid: 16 Other: 2 Total: 29</p> <p>These deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 25, 2021.</p>	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint Survey. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance	
------------------------	--	--------	---	--

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2021	
NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED 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			
F 0684 SS=D Bldg. 00	<p>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.</p> <p>Based on record review and interview, the facility failed to complete neurological assessments according to facility policy on a resident after an unwitnessed fall (Resident K), and failed to have hospice medical records at the facility for a resident on hospice (Resident E), for 2 of 3 residents reviewed for Quality of Care.</p> <p>Findings include:</p> <p>1. The clinical record for Resident K was reviewed on 3/22/21 at 12:02 p.m. Diagnoses included, but were not limited to, conductive hearing loss, unspecified lack of coordination, difficulty in walking, schizoaffective disorder, and dementia in other diseases classified elsewhere with behavioral disturbance.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 1/31/20, indicated Resident K had severe cognitive impairment and had fallen in the last month prior to admission. The resident required extensive two person assistance for bed mobility, transfer and toilet use.</p> <p>A current care plan indicated Resident K was at risk for falls due to a history of recent falls.</p>	F 0684	<p>1. What corrective actions(will) be accomplished for those residents found to have been affected by the deficient practice? DON/Designee will be responsible for monitoring the Hospice notes and updates to the patient's record. Licensed nursing staff will be in-serviced on the policy regarding neuro checks, intervals, and documentation on the neuro check screening form. They will also in-service staff on Hospice Binder. Date of completion for in-services April 9th, 2021</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility does not have any</p>	04/22/2021			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Interventions included, but were not limited to, keep call light in reach, notify and update provider as needed, therapy as indicated, and non-skid socks while in bed and out.</p> <p>A nurse's note, dated 2/12/20 at 8:28 a.m., indicated Resident K was found laying on the floor next to the bed with an abrasion and small amount of blood noted to the top of the resident's left hand. No other injuries were noted and neurological assessments were initiated.</p> <p>Review of a Neurological Assessment Log, provided by the ADON (Assistant Director of Nursing) on 3/22/21 at 2:43 p.m., indicated a lack of documentation for pulse, speech, and response for the first seven assessments on 2/12/20. The Neurological Assessment Log indicated a lack of neurological assessments after 26 hours of the initiated neurological checks.</p> <p>During an interview on 3/22/21 at 2:43 p.m., the ADON indicated she was still looking for the second page of neurological assessments for Resident K's unwitnessed fall on 2/12/20. Further information was not provided.</p> <p>During an interview on 3/23/21 at 9:04 a.m., Licensed Practical Nurse (LPN) 3 indicated neurological assessments were required to be completed for 72 hours after any unwitnessed fall. She indicated the neurological assessments included blood pressure, pulse and respirations. She indicated the facility required neurological assessments performed four times at every 15 minutes, two times at every 30 minutes, two times at every hour, then every shift thereafter for the duration of 72 hours.</p> <p>During an interview on 3/23/21 at 10:40 a.m., the</p>		<p>current hospice patients at the present time. All residents have the potential to have falls. Look back of 30 days of falls and any concerns have been addressed.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Hospice notes at each nursing station for nursing staff to have access. DON/Designee will be responsible for monitoring the Hospice notes and updates to the patient's record. Licensed nursing staff will be in- serviced on the policy regarding neuro checks, intervals, and documentation on the neuro check screening form.</p> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</p> <p>Compliance Tool will be utilized to monitor for compliance weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>ADON indicated during an unwitnessed fall, the facility required the nursing staff to immediately initiate neurological checks to include pupil assessment, reaction, strength in extremities, and vital signs (blood pressure, pulse, respirations, and temperature) for a duration of 72 hours.</p> <p>During an interview on 3/23/21 at 10:44 a.m., the ADON indicated the Neurological Assessment Log for Resident K's unwitnessed fall on 2/12/20 lacked complete documentation. Further documentation was not provided.</p> <p>A current policy, titled, "INCIDENTS/ACCIDENT/FALLS," provided by the DON (Director of Nursing) on 3/23/21 at 8:51 a.m., included, but was not limited to, the following: "Policy: It is the policy of the facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge... Procedure:... 2. In the case of a fall, the resident will have a head to toe assessment in include a pain assessment and assessment as to any change... Further, residents who have an unwitnessed fall must have neuro checks started and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed fall..."</p> <p>A current facility policy, titled, "Accident and Incident: Neurological Checks Guidelines," provided by the DON on 3/23/21 at 9:06 a.m., included, but was not limited to, the following: "...III. Procedure a. If a resident is involved in an incident/accident an immediate assessment of the resident is completed by the nurse... i. If a resident has an unwitnessed fall...neurological checks will be completed at intervals to ensure that a head injury has not occurred. 1.</p>		threshold of 100% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Neurological checks consist of the obtain of vital signs, pupillary responses, orientation status, skin check, and range of motion ability. 2. The intervals...to complete neurological checks are as follows: a. Every 15 minutes X 1 to equal 1 hour b. Every 30 minutes X 2 to equal 1 hour c. Every 1-hour X 2 equal to 2 hours d. Once per shift X 72 hours..."2. The clinical record for Resident E was reviewed on 3/23/21 at 9:35 a.m. Diagnoses for the resident included, but were not limited to, cerebrovascular disease, chronic obstructive pulmonary disease, anxiety, and major depression.</p> <p>Current signed physician's orders for the resident included, but were not limited to, the following order:</p> <p>a. Admit to Hospice for COPD (chronic obstructive pulmonary disease) and CVA (cerebrovascular disease). The order originated on 5/24/2017.</p> <p>The resident had a quarterly Minimum Data Set (MDS) assessment, dated 8/16/20, which indicated the resident had a condition or chronic disease that may result in a life expectancy of less than six months. Section O-0100 indicated the resident was receiving hospice services.</p> <p>The resident had a current, updated on 8/22/20, health care plan with the problem of "Resident receives hospice services".</p> <p>During an interview on 3/23/21 at 3:30 p.m., the ADON (Assistance Director of Nursing) indicated the facility did not have the resident's hospice documentation in the facility. She had to request documentation from the hospice provider to send copies of Resident E's hospice documents.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP COD 2400 CHATEAU DR MUNCIE, IN 47303
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>During a follow-up interview on 3/23/21 at 3:43 p.m., the ADON indicated the hospice company had been conducting telehealth visits with the nurses during the COVID-19 pandemic. She indicated the facility nurses conducting the visits should provide any pertinent information on the 24-hour communication sheet. The facility had no written documentation regarding the telehealth visits from the hospice nurse.</p> <p>During an interview on 3/23/21 at 3:50 p.m., LPN 1 indicated she did not have access to hospice paperwork and would have had to call the hospice nurse if the resident condition warranted additional information.</p> <p>Review of the current facility contract, signed by the Administrator on 2/4/2013, titled "Skilled Nursing Facility Contract," provided by the ADON on 3/23/21 at 10:40 a.m., included, but was not limited to,</p> <p>"Whereas, Hospice administers a program of palliative and supportive services, including interdisciplinary care services to meet the physical, psychological, social, and spiritual need of terminally ill persons and their families; and assures the continuity of patient /family care in an inpatient settings at the same level and to the same extent as those services would be provided if the resident were in his/her own home...</p> <p>1. Services to be furnished by the facility... the facility agrees that services may be provided and ensures that the needs of the patients are addressed and met 24 hours a day..."</p> <p>This federal tag relates to complaints IN00320334 and IN00335293.</p>			