STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(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	This visit was for the Investigation of Complaint IN00403887. Complaint IN00403887 - Federal/state deficiency related to the allegations is cited at F580. Unrelated deficiencies are cited. Survey dates: March 16 and 17, 2023. Facility number: 000134 Provider number: 155229 AIM number: 100275430 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 7 Medicaid: 49 Other: 12 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 22, 2023.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a desk review (compliance) by 04-07-2023	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

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

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify a severely cognitively impaired resident's family (Resident B) of a fall resulting in a transfer to the emergency room and admission to the hospital for a fractured right hip. Using the reasonable person concept, it is likely the resident experienced fear, anxiety, and pain, which would have been lessened by the presence of a loved one, during hospital treatment. Findings include: The clinical record for Resident B was reviewed on 3/16/2023 at 10:07 a.m. Diagnoses included vascular dementia, type 2 diabetes, hypertension, and abnormalities of gait and mobility. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/20/2022, indicated the resident was severely cognitively impaired. Review of a progress note dated 2/10/2023 at 2:00 p.m., indicated the facility called the hospital for an update on the resident after a fall, and was told the resident had a fractured right hip. The note indicated the Director of Nursing (DON), physician, and family were aware. Review of a hospital x-ray report, dated 2/10/2023 at 8:13 p.m., indicated the resident had a significantly angulated proximal right femoral fracture. Review of the hospital discharge summary, dated 2/14/2023, indicated the resident admitted with a right femoral fracture. Orthopedics was consulted	F 0580	1. Resident B no longer resides in facility. 2. Other residents have the potential to be affected therefore an IN house audit of a CIC for last 30 days will be completed to ensure no issues. Any issues identified will be addressed immediately before date of compliance. 3. Education will be completed to licensed nursing staff and therapy on the policy of notification to families and or POAS for condition changes. If responsible party does not answer then a message will be left and all attempts documented in the clinical record. This education will be completed by date of compliance and no licensed staff will work past that date. This education will be completed in orientation and annually as well as PRN. 4. Any CIC will be reviewed in morning meeting during normal business days for timely notification of appropriate individuals ongoing. DON/Designee must be notified of all condition changes and transfers therefore they will monitor on weekends and holidays. 5. Date of Compliance: 04-07-23	04/07/2023

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	and the resident was deemed to be a high perioperative mortality risk. Family was educated on the risk benefits of surgical intervention and opted to place the resident on hospice care. The resident had died on 2/13/2023. During an interview on 3/16/2023 at 10:40 a.m., the DON indicated the facility had not notified the resident's family of the fall, or the resident's transfer to the hospital, due to a miscommunication between nursing and the therapy department. During an interview on 3/16/2023 at 12:00 p.m., CNA 6 indicated on 2/10/2023 the resident had been observed ambulating with a walker. The resident attempted to sit on a bench located in the hallway. When the resident approached the bench, they stumbled and sat on the edge of the bench, slid off the bench and landed on the floor. During an interview on 3/16/2023 at 12:30 p.m., LPN 7 indicated she was called to the locked unit to assist with a fall. When she arrived the resident was observed on the floor. She instructed staff not to move the resident. She assisted LPN 5 with the process of sending a resident to the hospital. LPN 7 indicated one of the therapists, she did not know their name, stated she had spoken with the family and they were aware. Later, they discovered the family had not been notified of the fall. During an interview on 3/17/2023 at 12:32 p.m., the resident's daughter indicated she was very upset the family had not been notified the resident had been sent to the hospital after falling. The resident's spouse had arrived at the facility around 5:00 p.m. to have their evening meal with the resident, per his normal routine, and found out			

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	the resident had been sent to the hospital. The resident's husband called the daughter at approximately 5:00 p.m. and told her the resident was in the hospital. She immediately went to the hospital. The resident had been left alone at the hospital for approximately three hours. During an interview on 3/17/2023 at 12:41 p.m., CNA 1 indicated she arrived to work on 2/10/2023 for the 2:00 p.m. to 10:00 p.m. shift. When she arrived, the resident was observed on the floor and being sent out to the hospital. Between 5:00 p.m. and 5:30 p.m., the resident's husband arrived on the unit. She asked him if he knew his wife had been sent to the hospital, and he said no and left the facility". This Federal tag relates to complaint IN00403887. 3.1-5(a)(1) 3.1-5(a)(4)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific			

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	competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on record review and interview, the facility failed to ensure new nursing hires received appropriate supervision during the orientation process. Findings include: The clinical record for Resident B was reviewed on 3/16/2023 at 10:07 a.m. Diagnoses included: vascular dementia, type 2 diabetes, hypertension, and abnormalities of gait and mobility. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/20/2022, indicated the resident as severely cognitively impaired. Review of a facility reportable investigation, dated 2/10/2023, indicated Resident B fell while ambulating independently with a walker. The resident was sent to the hospital for evaluation and treatment. The resident was admitted to the hospital with a diagnoses of a fractured right hip.	F 0726	1. LPN # 5 was being trained on the floor by LPN # 12. She had already received general orientation with the LPN trainer for 2 days and then went to floor with the LPN # 12. LPN # 5 had a valid nurses license and followed appropriate protocol. 2. Other residents have the potential to be affected therefore an IN house RN trainer/Designee has been assigned to train all new forward. 3. Education/Orientation will be provided to licensed nurses upon hire that includes the following: nurses will spend 3 days with the LPN trainer to cover general orientation, including computer based in services required. Days 4, 5, and 6 they will be on the floor with an RN trainer/Designee and orientation checklist will be	04/07/2023

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	During an interview on 3/16/2023 at 12:00 p.m., CNA 6 indicated on 2/10/2023 the resident was observed ambulating with a walker and attempted to sit on a bench located in the hallway. When the resident approached the bench, they stumbled and sat on the edge of the bench, slid off the bench, and landed on the floor. During an interview on 3/16/2023 at 11:40 a.m., LPN 5 indicated on 2/10/2023 she was on orientation on the secured memory care unit. The nurse responsible for her orientation, LPN 12, had gone to lunch and left her on the unit with two CNAs (Certified Nursing Aides). LPN 5 had become a nurse in November 2022 and 2/10/2023 had been her second day of orientation on a nursing floor. During an interview on 3/16/2023 at 12:30 p.m., LPN 7 indicated she was called to the secured unit to assist with a resident who had fallen. When she arrived, the resident was observed on the floor. She assisted LPN 5 with the process of sending a resident to the hospital. LPN 7 indicated someone from the therapy department, she did not know their name, stated she had spoken with the family and they were aware. Later, they discovered the family had not been notified. During an interview on 3/16/2023 at 11:46 a.m., the Director of Nursing (DON) indicated the facility did not have a written orientation plan, program or guidelines. The DON indicated LPN 5 should not have been left unsupervised on the nursing unit During an interview on 3/17/2023 at , LPN 12 indicated she had went to lunch and left LPN 5 on the floor unsupervised. LPN 12 felt LPN 5 would be alright by herself, unsupervised.		completed and filled out and placed in personal file. DON/Designee will interview nurse being trained to see if they feel comfortable with this training once completed. If not DON/Designee will ensure specific issues are addressed prior to taking assignment on the floor. If nurse trainer must leave she will have another staff nurse cover with the orientee until she/he returns. 4. Don/Designee will review all orientation material for licensed nurses once completed and prior to nurse taking a floor assignment ongoing. Audits will presented to QAPI x 6 months and QAPI will determine the need for audits. 5. Date of Compliance: 04-7-23 IDR Request The nurse left on the floor had been a nurse for 3 months and had a valid nursing license. Our staff that works the Dementia unit have always been told if they need help to get another nurse in the facility to assist if needed, which is exactly what she did per 2567 and her interview. We feel that shows her competence in taking the proper actions. The dementia unit is a secured memory care unit and is behind locked doors, therefore there will be occasion's when they will need assist from other nurses in the facility. There is no regulation that states a	

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	During an interview on 3/17/2023 at 2:49 p.m., LPN 8 indicated she had oriented new nursing hires in the past. She would never leave a new hire on the floor unsupervised. Breaks and lunches should be taken at the same time. During an interview on 3/17/2023 at 9:30 a.m., RN 10 indicated she had oriented new nursing hires in the past. They would not leave a new hire on the floor unsupervised. Breaks and lunches should be taken at the same time. During an interview on 3/17/2023 at 9:37 a.m., LPN 11 indicated she had oriented new nursing hires in the past. They would not leave a new hire on the floor unsupervised. Breaks and lunches should be taken at the same time.		nurse in orientation can never be left alone without her trainer present.. This nurse did what any nurse would do under these circumstances. To cite the facility at F 726 for competent nursing staff did not occur. This nurse as stated above reacted exactly as she should have and requested assist form another nurse, she was not incompetent in any way. The facility agrees that our orientation process needs to improve and a plan is in place as you can see in the 2567 but at no time was there an incompetent nurse involved and again there is no regulation stating a nurse in orientation cannot be left alone at any time. The facility respectfully requests an IDR review for this tag.	