STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING _____ B. WING _____	06/18/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that a resident was free from physical abuse for 2 of 5 residents reviewed for abuse (Resident G and Resident F). Findings include: 1.A. Resident F's clinical record was reviewed on 6/16/20 at 3:00 p.m. [DIAGNOSES REDACTED]. A 4/13/20, Significant Change, MDS Assessment indicated the resident was unable to be interviewed for cognition. He had exhibited physical and verbal behavioral symptoms directed to others that had not significantly intruded on the privacy or activities of others. He had not exhibited wandering behavior. He had received an antidepressant every day during the assessment period. Progress Notes included, but were not limited to the following: A 5/10/20 change of condition note indicated the resident had been pushed to the floor by another resident. Neurological assessments were initiated and the medical doctor and director of nursing were notified. A 5/11/20 note indicated the interdisciplinary team had met to discuss the fall that occurred on 5/10/20, he was pushed to the floor by another resident. No injury noted at the time of the assessment. The intervention was for behavior management. A 5/13/20 note indicated follow up from fall, noted a scraped on the top of his head. Active care plans included, but were not limited to the following: A 1/24/19 care plan for fall risk related to impaired vision, unsteadiness on feet, impulsive behaviors, poor safety awareness, impaired cognition, muscle weakness, and lack of coordination. The goal indicated he would be free from injuries from falls, the target date was to have been 7/31/20. Interventions included, but were not limited to, concave mattress initiated on 4/29/20. A 2/5/20 care plan for risk for falls related to he had sometimes put himself on the floor, history of alls, muscle weakness, and behaviors. The goal indicated no fall related injuries, the target date was to have been 7/31/20. Interventions included, but were not limited to, low bed with mat initiated on 4/6/20. The care plans did not include information related to being pushed to the floor by another resident. B. During an observation, on 6/16/20 at 12:33 p.m., Resident F was walking in the hallway, he approached a resident sitting in a wheel-chair from behind and pushed the wheel-chair with the resident in it. The resident's clinical record was reviewed on 6/16/20 at 1:20 p.m. [DIAGNOSES REDACTED]. Current physician orders [REDACTED]. [MEDICATION NAME] (antipsychotic), 1.0 mg three times a day related to [MEDICAL CONDITION] disorder, order date 5/18/20. b. [MEDICATION NAME] (antipsychotic), 50 milligrams (mg) tablet, one tablet daily in the afternoon related to [MEDICAL CONDITION] disorder, order date 6/4/20. A 5/5/20, Admission, Minimum Data Set (MDS) Assessment indicated the resident was unable to be interviewed for cognition. He had physical and verbal behavioral symptoms directed at others, these significantly intruded on the privacy or activities of others, as well as wandering that significantly intruded on the privacy or activities of others. He had received an antipsychotic, on a routine basis, every day during the assessment period. Current care plans included, but were not limited to the following: A 4/30/20 care plan for [MEDICAL CONDITION] disorder with signs and symptoms of paranoid thoughts, delusions, hallucinations, confusion, and speaking too quickly. Interventions, all dated 4/30/20, included, but were not limited to, staff provided support and encouragement, and if needed, one on one time to discuss any difficult or troubling thoughts/feelings. A 4/30/20 care plan for little to no awareness of safety, or boundaries related to other's personal space. Interventions, Interventions, all dated 4/30/20, included, but were not limited to, when he was wandering, staff to ask him what he was looking for and re-direct him to his room or other places that have things he could rummage through safely without disturbing others. A 4/30/20 care plan for [DIAGNOSES REDACTED]. Interventions included, but were not limited to, allow the resident to walk throughout the secure unit at will, date initiated 4/30/20. A 5/4/20 care plan for behaviors that included: hitting staff, refusing care and placing his arm across staffs' necks. Interventions, all dated 5/4/20, included, but were not limited to, offer him something he liked as a diversion. Progress Notes included, but were not limited to the following: A 4/30/20 note indicated the resident required one on one to keep him out of other peers' rooms, the resident was not easily redirected. A 5/1/20 note indicated he was agitated and swinging at staff, he had been walking in the hallway going into other resident's rooms. A 5/2/20 note indicated he was moving furniture, tried to throw a dining room chair, and attempted to hit staff with his fist, he had been up wandering in the hall, in and out of other resident's rooms. A 5/3/20 note indicated he had thrown the digital video disc (DVD) player, had two staff against the wall on two different occasions with his arm across their throats threatening to hit them in the eye, he had been up wandering in and out of other's rooms. A 5/3/30 note indicated he shoved a staff member and stopped on their toes with his bare feet, he had been in the hall wandering in and out of other's rooms. A 5/10/20 behavior charting note indicated he was walking in the hallway and pushed another resident to the floor. The intervention was for redirection. A Psych Nurse Practitioner note, dated 5/14/20, indicated the resident had admitted to the facility from an inpatient psychiatric hospitalization , had been verbally and physically aggressive towards staff and peers at a previous extended care facility. During an interview, on 6/18/20 at 10:38 a.m., the Administrator indicated the incident on 5/10/20 was not reported to the state agency because there was no intent to cause harm, she considered it a fall. During an interview, on 6/18/20 at 10:53 a.m., the DON indicated Resident F put his hands up, and it was not really a shove, but they did make contact together. Review of a current facility policy, titled Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, with an effective date of 12/25/17 and provided by the Administrator, on 6/18/20 at 9:22 a.m., indicated .Definitions. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish .This presumes that instances of abuse of all residents even those in a coma, cause physical harm, or 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 of harm . This Federal Tag relates to Complaint IN 172. 3.1-27(a)(1)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and record review, the facility failed to report to the state agency a resident to resident altercation, for 2 of 5 residents reviewed for abuse (Resident's F and G). Findings include: A. Resident F's clinical record was reviewed on 6/16/20 at 1:20 p.m., and indicated a history of being aggressive and wandering into other resident rooms. Review of Resident F's progress note, dated 5/10/20 at 7:50 p.m., indicated he was walking in the hallway and pushed another resident to the floor. The intervention was for redirection. B. Review of Resident G's progress note, dated 5/10/20 at 7:46 p.m., indicated the resident was pushed to the floor by another resident. The medical doctor and director of

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 that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) nursing were notified. An interdisciplinary team note, dated 5/11/20, indicated the resident was pushed to the floor by another resident. The intervention was behavior management. Review of the facility's reportable events from the past 90 days did not include Resident G being pushed to the floor by Resident F. During an interview, on 6/18/20 at 10:38 a.m., the Administrator indicated the incident on 5/10/20 was not reported to the state agency because there was no intent to cause harm, she considered it a fall. During an interview, on 6/18/20 at 10:53 a.m., the DON indicated Resident F put his hands up, and it wasn't really a shove but they did make contact together, she considered this just a fall. Review of a current facility policy, titled Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, with an effective date of 12/25/17 and provided by the Administrator, on 6/18/20 at 9:22 a.m., indicated .24 Hour Reports: An initial report to the State Survey agency must be made within twenty-four (24) hours for all other reports or sooner id State law/regulations require a report within a shorter time frame .5 Day Reports: The results of all investigations must be reported .and to other officials in accordance with State law within 5 working days of the incident . This Faderal Tag relates to Complaint IN 172. 3.1-28(d)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure transmission-based precautions were implemented and communicated to staff for 3 of 5 residents reviewed for transmission-based precautions to mitigate the spread of COVID-19 (Residents B, C, and D). Findings include: 1. During a random observation, on 6/17/20 at 8:51 a.m., CNA 14 was observed inside the doorway of Resident B's room, speaking with another staff member. She was not wearing a gown, and the resident was in her bathroom. A sign on the resident's door indicated to see the nurse before entering. During an interview, on 6/17/20 at 9:02 a.m., CNA 14 indicated if there was a sign on the door to see the nurse before entering, it most likely indicated they were in isolation (transmission-based precautions), and required the use of a gown and other PPE by staff during care. On 6/17/20 at 12:59 p.m., Resident B was propelling herself in her wheelchair, accompanied by two staff members, from her room to the shower room, without a face covering on. A medical/procedure mask was hanging from the left handle of her wheelchair. A PPE cart and two barrels were observed in the resident's room. During an interview, at the time of the observation, the C Hall Unit Manager indicated the resident was in isolation because she had been in the hospital for surgery the previous week, so it wasn't really real isolation. The resident usually wore a mask when out, but sometimes was hard to redirect. Resident B's clinical record was reviewed on 6/17/20 at 1:48 p.m. [DIAGNOSES REDACTED]. She had no physician orders regarding transmission-based precautions. A 5/28/20, quarterly, Minimum Data Set (MDS) assessment indicated she had no speech, sometimes made herself understood, and usually understood others. She required extensive assistance for transfers, dressing, hygiene, and toileting. She was frequently incontinent of bowel and bladder. She had a 3/12/20 care plan problem of risk for COVID-19 related to risk for respiratory infection. Interventions included, but were not limited to, a 6/12/20, revised 6/18/20, intervention for staff to follow contact precaution for 14 days ending on 6/26/20. Review of a 6/11/20 progress note indicated she had left for a surgical appointment. A 6/13/20 progress note indicated she had returned to the facility with a surgical incision. During an interview, on 6/17/20 at 2:24 p.m., the DON indicated the resident was in isolation. The residents in transmission-based precautions in the facility were all 14 day preventative and on contact precautions. They should all have physician orders for contact precautions and have care plans reflecting it. A subsequent review of the resident's physician orders on 6/17/20 at 3:30 p.m., indicated a physician order for [REDACTED]. During an observation of PPE availability on the ACU and AACU hallways, on 6/28/20 at 9:58 a.m., a PPE supply cart was observed in the center of room [ROOM NUMBER]. There were clothing items on top of the cart, which caused the top of the cart to collapse into the top drawer of PPE. There was no signage on the door to the room. Another PPE cart was observed in the center of room [ROOM NUMBER]; there was no signage on the door. During an interview, at the time of the observation, LPN 11 indicated the PPE in room [ROOM NUMBER] may have been there because the resident (Resident C) was a newer admit. The resident was sitting in a wheelchair at the front porch area of the unit, with a group of residents. The residents were not wearing face coverings. She indicated room [ROOM NUMBER] belonged to Resident D, who had not been at the facility long, so he also had a PPE cart. The resident had been walking in the hallway during the observation, and was not wearing a face covering. Resident C's clinical record was reviewed on 6/18/20 at 10:25 a.m. She had admitted to the facility on [DATE] from a hospital. [DIAGNOSES REDACTED]. She had no physician's order for transmission-based precautions. Review of 6/12/20 Social Service note indicated they had talked to the resident's family about moving from C Hall to AACU. The family asked about isolation, and was informed she would be in her own room. When asked about socialization, she was told staff would encourage her to stay in her room, but would be able to socialize after her quarantine. She had a 6/16/20 care plan problem of risk for signs and symptoms of COVID-19 related to risk for respiratory infection. Interventions included, but were not limited to, follow facility protocol for COVID-19 screening and precautions, and staff to follow standard precautions. 3. Resident D's clinical record was reviewed on 6/18/20 at 10:40 a.m. He had admitted to the facility on [DATE] from a hospital. [DIAGNOSES REDACTED]. He had no physician's order for transmission-based precautions. He had a current 6/9/20 care plan problem of risk for signs and symptoms of COVID-19 related to risk for respiratory infection. Interventions included, but were not limited to, follow facility protocol for COVID-19 screening/precautions, and staff to follow standard precautions. During an interview, on 6/18/20 at 10:55 a.m., the DON indicated the facility protocol was to have residents in quarantine for 14 days after admission. If a PPE cart was in a resident's room, it would suggest they were on transmission-based precautions. She encouraged the use of signage on the doors. Residents on precautions should have had both physician's orders, and a care plan, to indicate the use of precautions for 14 days. Review of a current facility policy, titled Isolation-Categories of Transmission-Based Precautions, revised 6/24/18 and provided by the DON on 6/18/20 at 9:36 a.m., indicated the following: Contact Precautions .In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment . d. Gown 1) Wear a disposable gown upon entering the Contact Precautions room .g. Signs - the facility will implement a system to alert staff to the type of precaution the resident requires .2) The facility will also ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident . Droplet Precautions .In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets .that can be generated by the individual coughing, sneezing, talking .d. Resident Transport .2) If transport or movement from the room is necessary, place a mask on the infected individual . 3.1-18(a)