

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/23/2024
NAME OF PROVIDER OR SUPPLIER  Morrison Woods Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE  4100 N Morrison Rd 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50721</p> <p>Based on interview and record review, the facility failed to ensure consistent documentation and communication related to a resident's choice for advance directives for 1 of 8 residents reviewed for advance directives (Resident 35).</p> <p>Finding include:</p> <p>Resident 35's record was reviewed on [DATE] at 2:26 p.m. Diagnoses included rhabdomyolysis, severe sepsis with septic shock, acute respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic chronic kidney disease, and unspecified dysphagia.</p> <p>A physician order, dated [DATE], included a code status of Full Code (perform Cardiopulmonary Resuscitation or CPR).</p> <p>A current face sheet indicated he was a full code.</p> <p>A current electronic Continuity of Care document in the electronic health record indicated he had signed a Do Not Resuscitate (DNR) form.</p> <p>The resident's current code status care plan, dated [DATE], indicated that the resident/ resident representative had chosen his advance directives to include a code status of full code and those advance directives would be honored. Reviews to the advance directives were to be completed quarterly and as needed.</p> <p>A Nurse Practitioner's progress note, dated [DATE], indicated the resident's code status was reviewed with the resident. It indicated he was a full code and his code status was reviewed and updated.</p> <p>During an interview, on [DATE] at 2:51 p.m., the DON indicated when evaluating a code status for a resident in need of CPR, she looked for verification in the Continuity of Care document. This was the location where she educated nursing staff to look for a resident's code status. The DON verified Resident 35's Continuity of Care document, signed by the resident, indicated he did not want CPR and was a DNR. However, his face sheet and his physician's order both indicated a Full Code status. These discrepancies would make it difficult to assess the resident's wishes in the event of need for CPR and should all list the same status.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on [DATE] at 2:58 p.m., LPN 6 indicated he verified a resident's code status from the face sheet. Resident 35's face sheet listed him as a full code which meant if needed, staff would perform CPR on Resident 35. LPN 6 would initiate CPR on any resident until the code status was proven to be a DNR.</p> <p>A current facility policy, dated [DATE] and provided by the DON on [DATE] at 2:53 p.m., titled Guidelines for Advance Directives, indicated the purpose of the care plan was .to ensure facility staff obtains and follows resident's advance directives regarding end of life care nursing staff will obtain an order from the attending physician for the desired code status Designation of code status and obtainment of physician order will be part of the medical record</p> <p>3XXX,d+[DATE](f)(8)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>09676</p> <p>Based on observation, interview, and record review, the facility failed to implement preventative measures following an injury of unknown origin for 1 of 1 residents reviewed for injuries of unknown origin (Resident 24).</p> <p>Findings include:</p> <p>Resident 24's clinical record was reviewed on 8/20/24 at 3:33 p.m. Current diagnoses included dementia and Parkinson's Disease. The resident had an order for one antiplatelet medication, aspirin 81 mg taken one time daily.</p> <p>A 5/8/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, had mobility impairment in both the upper and lower extremities, and required staff assistance for bed mobility.</p> <p>A 7/29/24, 12:18 p.m., progress note indicated, while providing care, a CNA had observed a 9.5 centimeter (cm) long by 12 cm wide bruise on the inside of the resident's right knee. The bruise was purple/black in color. The bruise was tender to touch. The charge nurse was informed of the bruise.</p> <p>A 7/29/24, Wound Management Detail Report indicated the resident had a 9.5 cm by 12 cm black and purple bruise. This document was completed by LPN 8.</p> <p>A 7/30/24, Statement of Witness Form indicated LPN 8 had stated she was informed of Resident 24's knee bruise the day before when she had been the nurse on duty for the resident's hall. The form indicated the LPN had identified the bruises most likely likely cause as the resident's legs were contracted (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), and his knees were very knobby. Staff placed pillows between his knees when they laid him down, however due to his disease progression, he got restless in bed and kicked/pulled the pillow off. He also used a mechanical lift for transfers and the way the sling positioned with his legs, the sling could have contributed to the bruising.</p> <p>The resident had a current care plan problem/need regarding the potential for bleeding and bruising related to medication. This problem originated 4/1/23. No new approaches were added to this care plan problem following the 7/29/24 bruise.</p> <p>The record lacked care plan interventions or preventative approaches to reduce the risk for knee bruising due to knee contractures, removing the pillow from between his knees, and/or the bruising risk associated with using a full body mechanical lift.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/23/24 at 11:32 a.m., QMA 7 indicated the resident had contractures. She was aware the resident had experienced a recent bruise to his knee. The staff placed pillows between the resident's knees. The resident frequently removed the pillow. She did not know of any updates or changes that had made since the resident had developed a bruise on his knee. Staff just continued to place the pillow between his knees and he sometimes removed or displaced it. She had never received any new or specific information about transferring the resident with a full body lift in a manner to reduce bruising.</p> <p>During an interview on 8/23/24 at 11:23 a.m., the Administrator and Assistant Director of Nursing both indicated related to Resident 24's injury, the root cause analysis had identified the most likely cause to be contractures to the knees, restless leg, removing the pillow between his knees, and the use of an anticoagulant medication as the medically likely cause of the bruising.</p> <p>During an interview on 8/23/24 at 11:48 a.m., the Administrator indicated the facility had not developed and implemented new approaches to prevent recurrence of bruising after completing the root cause analysis identified contractors, rubbing knees together, and knees touching while transferring in a mechanical full body lift were the most likely causes of the bruising on the resident's legs.</p> <p>3.1-35(a)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>48146</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed regarding oxygen administration for 1 of 1 resident reviewed for respiratory care. (Resident 261)</p> <p>Findings include:</p> <p>During an observation, on 8/19/24 at 1:28 p.m., Resident 261 was lying in bed, eyes closed. He was wearing a nasal cannula. The oxygen concentrator was on at 3 liters per minute.</p> <p>During an observation, on 8/20/24 at 9:55 a.m., he was lying in bed. The head of the bed was elevated 90 degrees. He was wearing a nasal cannula. The oxygen concentrator was on at 3.5 liters per minute.</p> <p>During an observation, on 8/20/24 at 11:30 a.m., the resident was seated upright in bed. He was not wearing a nasal cannula. An oxygen mask was lying across his lap. During an interview, at the time of the observation, he indicated he had a heart attack earlier in the week and the doctor had him using oxygen for a few days.</p> <p>During an observation, on 8/21/24 at 10:19 a.m., Resident 261 was lying in bed. He was not wearing a nasal cannula. During an interview, at the time of the observation, he indicated he was a little short of breath.</p> <p>During an observation, on 8/21/24 at 3:35 p.m., the resident was seated upright in his bed visiting with family. He was not wearing a nasal cannula. During an interview, at the time of the observation, he indicated he did not feel well.</p> <p>During an observation, on 8/22/24 at 8:32 a.m., Resident 261 was lying in bed. He was not wearing a nasal cannula. The oxygen concentrator was off and against the wall by the head of bed.</p> <p>Resident 261's clinical record was reviewed on 8/21/24 at 4:05 p.m. Diagnosis included metabolic encephalopathy, unspecified atrial fibrillation, essential hypertension, and unspecified sepsis. The resident's admitted d was 8/16/24.</p> <p>A current physician's order, dated 8/19/24, indicated the following: send to emergency room if oxygen saturation is below 85 % on 4 liters per minute of oxygen or if mental status changes.</p> <p>A respiratory care plan, initiated 8/19/24, indicated to administer oxygen per physician's order and as needed and to elevate head of bed or place in upright position as needed.</p> <p>A vital sign record, on 8/19/24 at 11:31 p.m., indicated the resident's oxygen saturation was at 95%, and the resident was on 2 liters of oxygen per minute.</p> <p>A vital sign record, on 8/20/24 at 11:36 p.m., indicated the resident's oxygen saturation was at 95%, and the resident was on 2 liters of oxygen per minute.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A vital sign record, on 8/21/24 at 11:18 p.m., indicated the resident's oxygen saturation was at 96%, and the resident was on 2 liters of oxygen per minute.</p> <p>A physician's progress note, dated 8/21/24 at 9:56 p.m., indicated the resident had an acute hypoxia episode during breakfast on Monday, 8/19/24 and was started on oxygen at 4 liters per minute. The plan was to wean the resident off the oxygen as tolerated but to send to the emergency room if oxygen saturation is below 85 % on 4 liters per minute of oxygen or if oxygen saturation is below 90% on room air.</p> <p>During an interview, on 8/22/24 at 8:45 a.m., RN 5 indicated Resident 261 did not wear oxygen and she was aware of the order to send him to the emergency room if his oxygen saturation was below 85% on 4 liters per minute of oxygen.</p> <p>During an interview, on 8/22/24 at 8:47 a.m., the ADON indicated she would need to call the physician and get clarification for the order as the resident was not wearing oxygen at this time.</p> <p>During an interview, on 8/22/24 at 3:00 p.m., Corporate Nurse Consultant indicated the order for Resident 261 to wear oxygen should have been a one time order related to his cardiac event earlier in the week and needed discontinued. She was not able to locate a titration order for the resident.</p> <p>A current facility policy, reviewed 12/31/23 and titled, Guidelines for Medication Orders, provided by the DON on 8/23/24 at 11:15 a.m., indicated the following: .2. A current list of orders will be maintained in the electronic medical record or each resident 6. Oxygen orders a. When recording oxygen orders specify: 1. The rate of flow, route, and rationale (i.e: 02, 2L/min per nasal cannula PRN for SOB.) .</p> <p>3.1-47(a)(4)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48146</p> <p>Based on record review and interview, the facility failed to ensure narcotic reconciliation per facility policy for 2 of 3 medication carts reviewed for medication storage. (100 Hall and 300 Hall)</p> <p>Finding include:</p> <p>1. During a medication storage observation of the 100 hall cart, accompanied by LPN 9 on 8/23/24 at 9:49 a. m., the Narcotic Count Sheet record was reviewed and the following dates lacked shift to shift reconciliation of controlled medications:</p> <p>In July 2024-</p> <p>7/1/24- on day and night shifts,</p> <p>7/6/24- on day shift,</p> <p>7/7/24- on evening shift,</p> <p>7/10/24- on day and evening shifts,</p> <p>7/16/24- on night shift</p> <p>7/17/24- on evening shift,</p> <p>7/19/24- on evening shift,</p> <p>7/20/24- on all three shifts,</p> <p>7/25/24- on all three shifts,</p> <p>7/26/24- on all three shifts,</p> <p>7/27/24- on all three shifts,</p> <p>7/28/24- on all three shifts,</p> <p>7/29/24- on all three shifts,</p> <p>7/30/24- on all three shifts,</p> <p>7/31/24- on all three shifts.</p> <p>In August 2024-</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8/2/24- on evening shift,</p> <p>8/3/24- on evening shift,</p> <p>8/4/24- on evening shift,</p> <p>8/5/24- on evening shift,</p> <p>8/7/24- on evening shift,</p> <p>8/10/24- on all three shifts.</p> <p>2. During a medication storage observation of the 300 hall cart, accompanied by LPN 10 on 8/23/24 at 11:04 a.m. the Narcotic Count Sheet record was reviewed and the following dates lacked shift to shift reconciliation of controlled medications:</p> <p>In July 2024-</p> <p>7/4/24- on evening shift,</p> <p>7/6/24- on day shift,</p> <p>7/7/14- on night shift,</p> <p>7/8/24- on evening shift,</p> <p>7/12/24- on evening shift,</p> <p>7/13/24- on night shift,</p> <p>7/14/24- on day shift,</p> <p>7/15/24- on day and evening shifts,</p> <p>7/16/24- on day shift,</p> <p>7/22/24- on evening shift,</p> <p>7/23/24- on day and evening shifts,</p> <p>7/29/24- on evening shift,</p> <p>7/30/24- on evening shift,</p> <p>7/31/24- on evening shift.</p> <p>In August 2024-</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8/1/24- on all three shifts,</p> <p>8/3/24- on night and evening shifts,</p> <p>8/4/24- on evening shifts,</p> <p>8/5/24- on evening shifts,</p> <p>8/13/24- on evening shifts,</p> <p>8/14/24- on night and evening shifts,</p> <p>8/15/24- on day and evening shifts,</p> <p>8/16/24- on night and day shifts,</p> <p>8/17/24- on evening shift,</p> <p>8/18/24- on evening shift,</p> <p>8/19/24- on evening shift.</p> <p>During an interview, at the time of the observation, LPN 10 indicated the narcotic sign in/sign out sheet was to be completed after the narcotic medication count and with the exchange of keys.</p> <p>During an interview, on 8/23/24 at 2:08 p.m., the DON indicated the expectation was for the narcotic count sheet to be completed at every shift change and at any time the medication cart keys change hands. The DON indicated she was not able to locate any additional count sheets.</p> <p>A current facility policy, reviewed on 12/31/23, titled, Guidelines for Narcotic Count, provided by the DON on 8/23/24 at 11:15 a.m., indicated the following: . 2. The narcotic book shall contain a sheet providing space for the off going and oncoming nursing staff to record their signature indicating the narcotics have been reviewed 5. Both staff members shall sign that the narcotic count is accurately reconciled</p> <p>3.1-25(b)(3)</p>		