

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2014
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NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
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F000000	<p>This visit was for the Investigation of Complaint IN00149215.</p> <p>Complaint IN00149215-Substantiated. Federal/state deficiencies related to the allegations are cited at F 309.</p> <p>Survey date: May 22, 2014</p> <p>Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800</p> <p>Survey team: Gwen Pumphrey, RN-TC Gloria Reisert, MSW</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census Payor type: Medicare: 14 Medicaid: 60 Other: 14 Total: 88</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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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F000309 SS=G	<p>Quality review completed on May 28, 2014 by Randy Fry RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure residents were assessed following a significant change in condition resulting in hospitalization for two residents. This deficient practice affected 2 of 6 residents reviewed for change of conditions. (Resident A and D).</p> <p>Findings include:</p>	F000309	<p><i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</i></p> <p>Res A no longer resides at the center.</p> <p>Res D has been reviewed by the IDT. The care plans have been</p>	06/21/2014

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	<p>1. The clinical record for Resident A was reviewed on 5/22/14 at 11:00a.m. Resident A was admitted to the facility on 4/16/14. He had diagnoses, including but not limited, to colon cancer, high blood pressure, anxiety, and anemia. Resident A was admitted to the facility for rehabilitation following a bowel resection surgery.</p> <p>The physical therapy note dated 4/23/14 and untimed stated, "....The writer then requested the patient ambulate one more time before ending tx[treatment] session. Pt [patient] stated he didn't (think) he could. Then immediately, pt closed his eyes and stated, "is there a doctor here?" This writer reported, "not right now but there is a nurse. Is something wrong ?" Pt [patient] responded with eyes closed, and reached for this writers arm, "I'm passing out." Pt [patient] continued to state while rubbing this writers arm, "I need a doctor, I am passing out." This writer then assessed patients vital signs. BP[blood pressure] was 148/70, HR [heart rate] was 79, and O2 [oxygen] saturation was 97%. Reported to patient his vital signs looked good , but that we would go back to his room and alert the nurse. Pt was agreeable, and continued to report, " I need a doctor, I am passing out." No changes in posture or alarming signs of a problem had occurred. Pt</p>		<p>updated to reflect the current resident status.</p> <p>A one time audit of current resident population has been completed for significant changes. Licensed Supervisory staff have been re-educated on notification of resident change of condition and episodic documentation policy and procedure.</p> <p>It is the responsibility of the Licensed Supervisory Nurses to provide necessary care and services. The DON/designee will be responsible to review identified condition changes and review MD/family notification, documentation, and assessment of the resident weekly for 12 weeks, monthly for 6 months, and then quarterly for 1 quarter. Any issues identified will be immediately addressed, 1:1 re-education provided, with disciplinary action as determined necessary, up to and including termination.</p> <p>The ADM/Designee will be responsible to review completed auditing and monitoring as per identified schedule. Results of the reviews will be forwarded to the Quality Performance Improvement Committee monthly for 3 months, and then quarterly for 3 quarters. Any further action will be as determined by the QPI committee.</p>		

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	<p>continued to be alert, awake, and able to participate in putting legs on leg rests. Once to the bed, this writer requested the CNA assist with lying patient down. Pt was MinA [minimal assist] for transfers before treatment session. Transfers back to bed was Mod A of 2 [moderate assist of 2 people] to complete. Pt did participate in pushing up from chair, and pivoting feet. Once in supine position, CNA alerted nurse. Nurse came to the room to assess patient as well. Pt appeared to fall asleep with no signs of distress or labored breathing. Pt consistently complains that he is cold. This writer applied blankets, opened bathroom door where there is a ceiling heater, and turned on heather. Pt and roommate will often keep room door closed to trap heat. Closed door. Roommate reported he would alert nursing if any changes were made. This writer was attempting to get next resident on caseload when roommate came out and said, "he is doing something weird with is hand." This writer alerted nursing, who again, assessed patient...."</p> <p>The nurses notes for Resident A included the following: 4/23/14 at 1:30a.m.-Rd [resident] rec [received] dly [daily] skilled care for colon resection. Is A &amp;O X3 [alert and oriented times 3]. Incont [incontinent] of</p>			

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	<p>B &amp;B [bowel and bladder]. assist of one for transfers. call light within reach can and does make needs known.</p> <p>-9:15p.m.-Res [resident] resting in bed with eyes closed. BP [blood pressure] 122/68 P[pulse] 61 R [respirations] T [temperature 97.6</p> <p>-3:00p.m.-late entry Res [resident in bed, stating he does not feel well and that he feels like he is going to pass out. Res [resident] denies pain or any specific needs. Just states he wants to rest. 142/74 74 18 97 97%. No acute signs of distress noted. Res [resident] A &amp;Ox3 [alert and oriented times 3]. able to answer questions appropriately. will continue to monitor.</p> <p>-3:15p.m.(late entry)Res [resident] abed resting with eyes closed. Res responds when spoke to. No signs or symptoms of distress noted. Resident noted to be grimacing at times but continues to state he does not have any pain or want anything for comfort. Resident says he still does not feel well but is unable to specify any needs. 137/69 72 16 97.2 96% accucheck 170</p> <p>-3:30p.m.(late entry) Res abed, staff at bedside. Resident denies pain but continues to grimace and unable to state why. PERRLA [a normal assessment of the eyes indicating pupils equal, round, and reactive to light and accommodation], hand grasps firm and</p>						

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	<p>equal, moves all extremities without difficulty. 141/71, 18, 97.1, 95% -4:30p.m. (late entry) Res abed no sign or symptoms of distress noted. Res denies pain or any needs at this time. Res states he is not hungry and does not want any supper. Res says he is still uncomfortable but does not want anything for pain, to get OOB [out of bed], or be repositioned at this time. Neuro checks remain within normal limits 147/76 76 97.1 96% -5:30p.m. (late entry)Res abed, appears to be sleeping, arouses easily when spoken to answers all questions easily when spoken to. answers all questions appropriately. resident did not eat any supper and states he does not want anything when offered by staff. 6:15p.m.-(late entry)Res abed with eyes closed. Easily awoken. Res denies any needs at this time. Vital signs stable. will continue to monitor.</p> <p>A document titled, "SBAR Communication Form" indicated on 4/24/14 at 6:25a.m. the physician was notified due to Resident A "unresponsive to verbal command or painful stimuli" The form also indicated Resident A's family was notified of his change in condition.</p> <p>Resident A was transferred to the hospital</p>						

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	<p>on 4/24/14 at 7:00a.m. and expired on 4/27/14 in the hospital.</p> <p>The radiology report from the hospital dated 4/24/14 at 1:26p.m. indicated Resident A had "...Multiple areas of recent infarction involving the right posterior cerebral artery distribution, both thalami, the mesencephalon, and both cerebellar hemispheres.</p> <p>The discharge summary dated 4/27/14 indicated Resident A had an acute stroke with coma. Resident A also had a possible leak from his bowel resection surgery. Resident A expired in the hospital on 4/27/14.</p> <p>On 5/22/14 at 9:30a.m., RN#1 indicated a resident's assessment with acute changes would prompt further monitoring. RN#1 also indicated he provided care for Resident A a few times but nothing "stood out about him medically."</p> <p>On 5/22/14 at 10:40a.m., Resident A's family member was interviewed. She indicated she inquired with both the day and night shift nurse on 4/23/14 if the resident was having a stroke. She stated both nurses indicated the resident was resting. She indicated neither nurse would come to the residents room to</p>						

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	<p>assess him. She felt that "they were just blowing me off."</p> <p>On 5/22/14 at 2:33p.m., the Director of Nursing indicated, "if the nurses use the SBAR it is the same as their nurses notes. If a resident is requesting to see the doctor, I would expect the nurses to assess what's going on with them, and depending on the circumstances I would follow notify the physician and follow his orders. If a family requests to see the physician, we would honor that."</p> <p>On 5/22/14 at 3:00p.m., this writer attempted to contact the nurse providing care for Resident A on 4/23/14. She was unavailable for interview.</p> <p>On 5/22/14 at 3:05p.m., the Physical Therapist (PT #1) was interviewed. PT#1 provided care for Resident A on 4/23/14. PT#1 reiterated her progress note, adding, "He was here for just a short time but he did really well. He was cooperative and compliant. I know that day I saw him after lunch, because he participated in all three (speech, occupational, and physical therapy). " PT#1 was unable to indicate the exact time of the therapy session.</p> <p>There was no documentation to indicate Resident A had a more thorough</p>			

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	<p>assessment being completed or the physician being notified until 9 hours after the resident requested to be seen by a physician.</p> <p>2. Review of the clinical record for Resident #D on 5/22/14 at 12:50 p.m., indicated the resident had diagnoses which included, but were not limited to: multiple sclerosis, neurogenic bladder and urosepsis.</p> <p>On 5/16/14, the resident was transferred to the hospital emergency room to have her suprapubic catheter changed. The Transfer Form indicated the reason to be "Catheter changed multiple times - needs suprapubic placement, not able to anchor catheter, increased urine retention".</p> <p>A 5/16/14 SBAR Communication Form [report form used to document change in condition in order to contact physician] completed at 3:20 p.m. indicated "It was reported to this nurse by 3rd shift nurse that cath [catheter] has been leaking around tubing all noc [night] [and] has been changed multiple x's [times]. When this writer came onto unit, I assisted in changing cath. Urine noted to drain around cath but not thru tubing. Message left [with] [name of urologist] r/t [related to] any N/Os [new orders]. MD returned call and stated to send res [resident] to</p>			

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	<p>ER to have cath replaced. N/O send to [name of hospital] ER. Resident was experiencing some nausea, distended abdomen, abdominal pain and tenderness also."</p> <p>The re-admitting diagnosis from the hospital transfer sheet indicated "Urosepsis [infection of bladder]" and that the resident required hospitalization between 5/16 to 5/20/14.</p> <p>During an interview with LPN #1 on 5/22/14 at 1:30 p.m., she indicated "I had just come on duty and had not even made rounds on my residents before the 3rd shift nurse got me and told me she had changed the resident's catheter multiple times during the night but that it was still leaking around. I watched her change it again but it was still leaking. We changed it again and was able to get it anchored, so I decided to monitor it for awhile before calling the MD. Around 9:30 a.m., I called her urologist because it kept leaking around the site and no urine was going into the bag. Did not get a call back after a while, so I called again and left a message. I called again around 3:00-3:15 p.m. and his nurse said she would tell him right now and a few minutes later I got a call back with an order to send her out to the hospital ER. She was admitted with urosepsis. I also learned from the</p>			

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	<p>urologist that within 12 minutes, her stoma could close up, causing all that leaking."</p> <p>During this interview with LPN #1, LPN #2 also joined the interview indicating they would not have waited until the next shift came on to call the MD. They indicated that although they might not have contacted the urologist, they would have made the call to the resident's primary physician to update him on the resident's condition and get new orders.</p> <p>Review of the nursing notes indicated there was no documentation from the 3rd shift nurse and the first shift nurse of any assessment of the resident's overall condition, the need to change the catheter multiple times, and of the phone calls to the urologist until the SBAR Communication Form was completed at 3:20 p.m. on 5/16/14..</p> <p>During an interview with the Director of Nursing on 5/22/14 at 2:30 p.m., she indicated if the nurse has to change the catheter at least 2 times and continued to have issues with it, there should be some type of documentation in the nursing notes. If having to change it multiple times, then reasonable expectations would be to call the primary physician even during the night, to inform him of</p>			

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	<p>the problems and obtain new orders if necessary.</p> <p>On 5/22/14 at 3:05 p.m., the Director of Nursing presented a copy of the "Signs and Symptoms - Immediate vs. Non-Immediate Notification to the Physician". Review of this book indicated "Urinary hesitancy or retention - Immediate - Abrupt decrease in urinary output, with lower abdominal distension, discomfort over bladder,..."</p> <p>A copy of the policy titled "Interact Care Path" was provided by the Director of Nursing on 5/22/14 at 3:02p.m. This documented indicated when family or patient have a medical complaint "demand to speak to a physician or have a medical assessment without delay."</p> <p>A copy of the policy titled, "Episodic Documentation" was provided by Medical Records on 5/22/14 at 12:50p.m. This policy effective October 2002, indicated, ..."will document significant resident care issues each shift until stabilized or the situation is otherwise resolved. 1. Enter the date and time of occurrence. 2. Document the facts regarding the care issue or incident as applicable, including but not limited to:vital signs, physical assessment, resident response, resident level of</p>			

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	consciousness, symptoms. 3. notify physician and document the following: a. date and time physician notified b. orders obtained 4. notify responsible party and document the following: date and time responsible party notified. b. name of responsible party member.  3.1-37(a)				