

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2015
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint Number IN00161643.</p> <p>Complaint IN00161643 Substantiated, Federal/State deficiencies related to the allegations are cited at F312.</p> <p>Survey Dates: January 12,13,14,15,16, 2015.</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Survey team: Tina Smith Staats, RN, TC Ginger McNamee, RN Karen Lewis, RN Toni Maley, BSW (January 13,14,15 and 16, 2015)</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 6 Medicaid: 37 Other: 2 Total: 45</p>	F000000	Submission of this Plan ofCorrection does not constitute and admission or agreement by the provider ofthe truth of facts alleged or corrections set forth on the statement ofdeficiencies. This Plan of Correction is prepared and submitted because of requirementsunder State and Federal law. Please accept this Plan of Correction as ourcredible allegation of 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 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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F000157 SS=D	<p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p>			

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	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure physicians were notified regarding blood sugars which were out of range for 2 of 4 residents reviewed for blood sugar monitoring. (Residents #45 and 40)</p> <p>Findings included:</p> <p>1. Resident #45's clinical record was reviewed on 1/14/2015 at 12:40 p.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus, hypertension, coronary artery disease, history of mitral valve prolapse, and congestive heart failure.</p> <p>The resident had current physician's orders signed on 12/19/14. The orders included but, were not limited to:</p> <p>1. accucheck [blood sugar check] before meals, bedtime, and 11:00 p.m. Call for blood sugar less than 60 or greater than 350. This order originated on 8/14/14.</p> <p>2. Novolog insulin 100 units/ml vial inject subcutaneously per sliding scale.</p> <p>Blood sugar of: 0 to 200 give no insulin 201 to 300 give 4 units insulin Greater than 301 give 6 units insulin.</p>	F000157	<p>F157</p> <p>1. Resident # 45's physician was notified of the 59elevated blood sugars in the past 3 months, which exceeded 350mg/dl, as well asthe two conflicting medication orders for sliding scale parameters. New orderswere received for new parameters. Resident # 40's physician was notified of the 4 elevated blood sugars inthe past 3 months, which exceeded 350mg/dl, as well as the conflictingmedication orders for sliding scale parameters. New orders were received fornew parameters.</p> <p>2. A chartreview was conducted for all other residents receiving sliding scale insulincoverage. Physician notified of any further abnormalities. All licensed nursingstaff were re-educated on the policy and procedure regarding blood glucosemonitoring, including but not limited to hyper/hypoglycemic reactions,notification of Change for parameters set forth by the physician, and assuringthere are no conflicting orders for parameters set forth by the physician.</p> <p>3.As a means to ensure compliance with propnotification of physician for abnormal blood glucose levels outside ofparameters set forth by the</p>	02/15/2015			

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	<p>Blood sugar less than 60 or greater than 400 notify M.D. Repeat accucheck in 2 hours and if it hasn't come down, notify the M.D. This order was marked as an FYI [for your information.] This order originated 4/28/14.</p> <p>Review of the November, 2014, Medication Administration Record [MAR] indicated the blood sugar monitoring and sliding scale insulin were recorded on the "Blood Glucose Monitoring/Sliding Scale insulin Record." Review of the "Blood Glucose Monitoring/Sliding Scale insulin Record" for November, 2014 indicated the resident had blood sugars greater than 350 on the following dates and times: 5th at 8:00 p.m. - 355 7th at 12:00 p.m. - 556 9th at 8:00 p.m. - 376 12th at 12:00 p.m. - 475 12th at 8:00 p.m. - 362 12th at 11:00 p.m. -360 13th at 11:30 a.m. - 484 14th at 11:30 a.m. - 434 15th at 12:00 p.m. - 351 15th at 4:00 p.m. - 391 18th at 12:00 p.m. - 424 21st at 4:00 p.m. - 365 22nd at 12:00 p.m. - 397 23rd at 12:00 p.m. - 400 23rd at 8:00 p.m. - 354 24th at 8:00 p.m. - 399</p>		<p>physician, all licensed nursing staff werere-educated on the policy and procedure regarding blood glucose monitoringIncluding but not limited to hyper/hypoglycemic reactions, notification ofChange for parameters set forth by the physician, and assuring there are noconflicting orders for parameters set forth by the physician. The DON and/or her designee will review allresidents' records which receive sliding scale insulin, to assure propnotification of physician for blood sugars outside of set parameters 5x/week on scheduled work days x 1 month,2x/week x 1 month, then weekly thereafter, should concerns be noted, correctiveaction shall be taken.</p> <p>4.As a means of quality assurance, the DON and/orher designee will report the findings of the above reviews and any correctiveactions taken to the QA committee monthly x 3 months and quarterly thereafter,and revisions made to the plan, if warranted.</p> <p>5.2-15-15</p>				

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	<p>25th at 8:00 p.m. - 355 26th at 12:00 p.m. - 397 27th at 8:00 p.m. - 415 28th at 8:00 p.m. - 364 29th at 8:00 p.m. - 399 30th at 8:00 p.m. - 396</p> <p>Review of the December, 2014, MAR and "Blood Glucose Monitoring/Sliding Scale insulin Record" indicated the resident had blood sugars greater than 350 on the following dates and times:</p> <p>1st at 11:30 a.m. - 373 1st at 8:00 p.m. - 397 2nd at 4:00 p.m. - 396 2nd at 9:00 p.m. - 582 2nd at 11:00 p.m. - 355 7th at 8:00 p.m. - 386 8th at 9:00 p.m. - 392 10th at 9:00 p.m. - 400 12th at 9:00 p.m. - 473 12th at 11:00 p.m. - 374 13th at 4:00 p.m. - 364 14th at 12:00 p.m. - 396 15th at 4:00 p.m. - 355 16th at 12:00 p.m. - 487 16th at 4:00 p.m. - 400 16th at 9:00 p.m. - 406 17th at 8:00 p.m. - 400 18th at 8:00 p.m. - 392 20th at 4:00 p.m. - 394 20th at 8:00 p.m. - 375 23rd at 8:00 p.m. - 400 26th at 8:00 p.m. - 366</p>			

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	<p>27th at 11:30 a.m. - 391 29th at 8:00 p.m. - 397 30th at 8:00 p.m. - 351 30th at 11:00 p.m. - 363 31st at 8:00 p.m. - 400</p> <p>Review of the January (1-14), 2015, MAR and "Blood Glucose Monitoring/Sliding Scale insulin Record" Indicated the resident had blood sugars greater than 350 on the following dates and times: 3rd at 12:00 p.m. - 389 4th at 12:00 p.m. - 421 4th at 4:00 p.m. - 392 8th at 12:00 p.m. - 362 8th at 9:00 p.m. - 367 9th at 12:00 p.m. - 384 11th at 12:00 p.m. - 380 13th at 9:00 p.m. - 382</p> <p>Review of the clinical record from November 1, 2014 to January 14, 2015, lacked an indication of the physician being notified of the 59 elevated blood sugars.</p> <p>Additional information related to physician notification of elevated blood sugars was requested from the RN Consultant and Director of Nursing on 1/16/15 at 9:30 a.m.</p> <p>No additional information was provided</p>			

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	<p>at time of exit on 1/16/15 at 3:54 p.m.</p> <p>2. The clinical record for Resident #40 was reviewed on 1/14/15 at 10:29 a.m. Diagnoses for Resident #40 included, but was not limited to, hypertension, diabetes, and schizoaffective disorder.</p> <p>A health care plan problem, dated 7/1/13, indicated Resident #40 had a diagnosis of diabetes mellitus and was at risk for experiencing hypoglycemia and hyperglycemia. Interventions for this problem included, but were not limited to, "document the results of the blood glucose tests, notification of the physician and responsible party, the specific treatment used, the resident's response to the treatment, and any follow up completed."</p> <p>Resident #40 had two current contradictory physician's orders for doctor notification for blood sugars out of range. The first order was to check blood glucose before meals and at bedtime, and call the physician if the blood glucose result was less than 60 or greater than 400. The original date of this order was 4/24/14. On 11/26/14, the resident received a new order to call the physician if the blood glucose result was less than 60 or greater than 450. Both orders remained current in the January 2015 Recapitulation of physician's orders.</p>			

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	<p>The November 2014 "BLOOD GLUCOSE MONITORING SLIDING SCALE INSULIN RECORD", indicated the following blood glucose results:</p> <p>November 2, at 5:00 p.m., the blood glucose result was 404.</p> <p>November 2, at 9:00 p.m., blood glucose result was 405.</p> <p>November 5, at 6:00 a.m., the blood glucose result was 420.</p> <p>November 5, at 5:00 p.m., the blood glucose result was 427.</p> <p>The clinical record lacked any information to indicate the physician had been notified of the blood glucose results greater than 400. There were no nursing note entries on 11/2/14. The nursing note, dated 11/5/14, did not mention Resident #40's blood glucose results.</p> <p>During an interview with the Director of Nursing on 1/16/15 at 10:28 a.m., additional information was requested related to the lack of physician notification of blood glucose results on November 2, and November 5, 2014. On 1/16/15 at the time of exit, no information regarding physician</p>			

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F000312 SS=D	<p>notification for Resident #40's elevated blood sugars had been provided by the facility.</p> <p>3. Review of the current facility policy, dated 10/2014, titled "HYPERGLYCEMIA TREATMENT", provided by the RN Consultant on 1/15/15 at 9:30 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Appropriate nursing care is provided to residents with Diabetes Mellitus who require insulin or oral hypoglycemic agents to minimize the risk of, and to ensure prompt recognition of, hyperglycemia....</p> <p>...2. If blood glucose is above the high end of normal range, notify physician as soon as possible for subsequent care orders....</p> <p>...6. Document pertinent observations in the clinical record."</p> <p>3.1-5(a)(3)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral</p>			

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	<p>hygiene.</p> <p>Based on interview and record review, the facility failed to ensure a dependent resident received showers to maintain good hygiene and grooming for 1 of 20 residents interviewed for services to provide good hygiene and grooming (Resident #B).</p> <p>Findings include:</p> <p>During an 1/13/15, confidential interview with Resident #B, who was deemed reliable during the stage one survey process, the resident stated he/she did not get to choose between a bed bath or shower and was offered bed baths only. Resident #B indicated a desire for showers. Resident #B indicated he/she only got a full bed bath one time a week and desired to be bathed more often. The resident indicated he/she required staff assistance and could not bath independently.</p> <p>Resident #B's clinical record was reviewed on 01/15/15 at 9:20 a.m. Resident #B's current diagnoses included, but were not limited to, anxiety, depression and obesity.</p> <p>Resident #B had a current, 12/18/14, admission, Minimum Data Set assessment (MDS) which indicated the</p>	F000312	<p>F312</p> <p>1. Resident B was immediately offered a shower. Resident B was interviewed to identify his bathing preferences. Care plan and C.N.A. assignment sheet updated as to preferences.</p> <p>2. All residents in need of assistance with bathing were identified and interviewed by the SSD and/or designee as to bathing preferences. Care Plans and C.N.A. assignment sheets updated accordingly. Nursing staff were re-educated on the policy for bathing and showers, including but not limited to resident preferences and following the resident shower schedules.</p> <p>3. As a means to ensure compliance with assuring residents bathing preferences are followed, Residents in need of assistance with bathing were identified and interviewed by the SSD and/or designee as to bathing preferences. Care Plans and C.N.A. assignment sheets updated accordingly. Nursing staff were re-educated on the policy for bathing and showers, including but not limited to resident preferences and following the resident shower schedules. The DON and or designee will monitor resident care records 5x/ week x 1 month, 3x/week x 1 month, then weekly thereafter, should</p>	02/15/2015			

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	<p>resident did not have cognitive impairment, was understood by others, usually understood others, and required assistance from staff for dressing, bathing and hygiene.</p> <p>Resident #B's clinical record, from admission through 1/15/15, did not indicate the resident refused care or treatment. Resident #B did not have a care plan regarding refusal of baths/showers or other care. Resident #B did not have a care plan which identified a preference or need for bed baths instead of showers.</p> <p>Resident #B had a 1/13/15, note from a psychiatric services provider which indicated his appearance was "unkempt."</p> <p>Review of Resident #B's "Resident Care Record", from 12/11/14 through 1/14/15 (a 35 day period), indicated the resident had received only 1 shower and 3 full bed baths during this 35 day period. The resident was documented as refusing on 1 day. All other bathing was documented as partial bed baths.</p> <p>A 1/15/15, review of the current, undated, CNA assignment sheet indicated Resident #B was assigned to receive showers 2 times a week (Tuesday and Thursday) during the day shift.</p>		<p>concerns be noted, corrective action shall be taken.</p> <p>4.As a means of quality assurance, The DON and/or designee will report findings of the above reviews and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan if warranted.</p> <p>5.2-15-15</p>		

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	<p>During an 1/15/15, 10:01 a.m., interview, CNA #1 indicated each resident had an assigned shower day listed on the CNA assignment sheet. She indicated, if a resident refused a bath or shower, it should be documented on the Resident Care Record and the nurse should be informed. She indicated she did not have any current residents who regularly refused showers or baths. CNA #1 was working in the area of the facility where Resident #B resided.</p> <p>During an 1/15/15, 10:02 a.m., interview, CNA #2 indicated she did not have any residents in her care area who regularly refused showers. She was working in the area of the facility where Resident #B resided. She indicated all residents had assigned shower days. She indicated when a resident refused a shower the nurse was notified and the refusal should be documented on the Resident Care Record.</p> <p>During an 1/15/15, 12:30 p.m., interview, LPN #3 indicated she was unaware of any resident in her area who was refusing showers or full bed baths. LPN #3 was assigned to Resident #B's area.</p> <p>During an 1/16/15, 2:00 p.m. interview, the Director of Nursing indicated she had</p>			

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F000329 SS=D	<p>not been aware of Resident #B's lack of full bed baths or showers. She indicated baths or showers were documented on the Resident Care Record. She indicated, if a resident refused a shower, the nurse should be notified in order to address the concern. She indicated Resident #B's lack of showers or refusal had not been addressed.</p> <p>A current, 10/2014, facility policy titled "Showering A Resident, which was provided by the RN Consultant on 1/16/15 at 2:45 p.m., indicated the following: "Purpose: a shower will clean, refresh, and soothe the resident, stimulate circulation, and provide as opportunity for the resident to exercise arms and legs. Policy: Resident will receive a shower at least twice weekly unless condition warrants otherwise or resident refuses."</p> <p>This Federal tag relates to Complaint IN00161643.</p> <p>3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive</p>						

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	<p>dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to monitor the effectiveness of insulin by checking blood sugars and blood pressure medications by checking the blood pressure and failed to ensure insulin doses were accurate for 2 of 5 residents reviewed for unnecessary medications. (Resident #'s 45, 40) In addition, the facility failed to monitor the pulse for 1 of 5 residents who was receiving digoxin to monitor the effectiveness of the medication usage (Resident # 45.)</p> <p>Findings include:</p> <p>1. A. Resident #45's clinical record was reviewed on 1/14/2015 at 12:40 p.m.</p>	F000329	<p>F 329</p> <p>1. Resident # 45's physician was notified of the 59elevated blood sugars which exceeded 350mg/dl, as well as the two conflicting medication orders for sliding scale parameters, 32 blood sugars without documentation, 8 times indicated of wrong doses of insulin per sliding scale, 13missing pulses for monitoring of Digoxin in the past 3 months. New orders werereceived for new parameters for blood sugar per sliding scale. Resident # 40's physician was notified of the 8 missing blood pressure measurements, no new orders were received at thistime.</p> <p>2. A chart review was conducted for all otherresidents receiving</p>	02/15/2015	

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	<p>The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus, hypertension, coronary artery disease, history of mitral valve prolapse, and congestive heart failure.</p> <p>The resident had current physician's orders signed on 12/19/14. The orders included but, were not limited to:</p> <ol style="list-style-type: none"> 1. Accucheck [blood sugar check] before meals, bedtime, and 11:00 p.m. Call for blood sugar less than 60 or greater than 350. This order originated on 8/14/14. 2. Novolog insulin 100 units/ml vial inject subcutaneously per sliding scale. Blood sugar of: 0 to 200 give no insulin 201 to 300 give 4 units insulin Greater than 301 give 6 units insulin. This order originated on 8/14/14. 3. Blood sugar less than 60 or greater than 400 notify M.D. Repeat accucheck in 2 hours and if it hasn't come down, notify the M.D. This order was marked as an FYI [for your information.] This order originated 4/28/14. <p>Review of the November, 2014, Medication Administration Record [MAR] indicated the blood sugar monitoring and sliding scale insulin were recorded on the "Blood Glucose Monitoring/Sliding Scale Insulin Record." Review of the "Blood Glucose</p>		<p>sliding scale insulin coverage, as well as monitoring of pulse and blood pressures for therapeutic drugs. Physicians notified of any further abnormalities. All licensed nursing staff were re-educated on the policy and procedure regarding Charting and Documentation including but not limited to: blood glucose monitoring, hyper/hypoglycemic reactions, monitoring of pulse and blood pressure for therapeutic medications, and proper documentation of the above.</p> <p>3. As a means to ensure compliance with proper documentation of blood sugars per sliding scale, monitoring of pulse and Blood pressure per physicians orders for therapeutic medications, All licensed nursing staff were re-educated on the policy and procedure regarding Charting and Documentation including but not limited to: blood glucose monitoring, hyper/hypoglycemic reactions, monitoring of pulse and blood pressure for therapeutic medications, and proper documentation of the above, The DON and other designee will monitor resident care records 5x/ week x 1 month, 3 x/week x1 month, then weekly thereafter, should concerns be noted, corrective actions shall be taken.</p> <p>4. As a means of quality assurance, the DON and/or other designee will report the findings</p>				

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	<p>Monitoring/Sliding Scale Insulin Record" for November, 2014 indicated the resident had blood sugars greater than 350 on the following dates and times:</p> <p>5th at 8:00 p.m. - 355 7th at 12:00 p.m. - 556 9th at 8:00 p.m. - 376 12th at 12:00 p.m. - 475 12th at 8:00 p.m. - 362 12th at 11:00 p.m. -360 13th at 11:30 a.m. - 484 14th at 11:30 a.m. - 434 15th at 12:00 p.m. - 351 15th at 4:00 p.m. - 391 18th at 12:00 p.m. - 424 21st at 4:00 p.m. - 365 22nd at 12:00 p.m. - 397 23rd at 12:00 p.m. - 400 23rd at 8:00 p.m. - 354 24th at 8:00 p.m. - 399 25th at 8:00 p.m. - 355 26th at 12:00 p.m. - 397 27th at 8:00 p.m. - 415 28th at 8:00 p.m. - 364 29th at 8:00 p.m. - 399 30th at 8:00 p.m. - 396</p> <p>Review of the December, 2014, MAR and "Blood Glucose Monitoring/Sliding Scale Insulin Record" indicated the resident had blood sugars greater than 350 on the following dates and times:</p> <p>1st at 11:30 a.m. - 373 1st at 8:00 p.m. - 397</p>		<p>of the above reviews and any correctiveactions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted. 5.2-15-15</p>				

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	<p>2nd at 4:00 p.m. - 396 2nd at 9:00 p.m. - 582 2nd at 11:00 p.m. - 355 7th at 8:00 p.m. - 386 8th at 9:00 p.m. - 392 10th at 9:00 p.m. - 400 12th at 9:00 p.m. - 473 12th at 11:00 p.m. - 374 13th at 4:00 p.m. - 364 14th at 12:00 p.m. - 396 15th at 4:00 p.m. - 355 16th at 12:00 p.m. - 487 16th at 4:00 p.m. - 400 16th at 9:00 p.m. - 406 17th at 8:00 p.m. - 400 18th at 8:00 p.m. - 392 20th at 4:00 p.m. - 394 20th at 8:00 p.m. - 375 23rd at 8:00 p.m. - 400 26th at 8:00 p.m. - 366 27th at 11:30 a.m. - 391 29th at 8:00 p.m. - 397 30th at 8:00 p.m. - 351 30th at 11:00 p.m. - 363 31st at 8:00 p.m. - 400</p> <p>Review of the January, 2015, MAR and "Blood Glucose Monitoring/Sliding Scale Insulin Record" indicated the resident had blood sugars greater than 350 on the following dates and times: 3rd at 12:00 p.m. - 389 4th at 12:00 p.m. - 421 4th at 4:00 p.m. - 392</p>			

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	<p>8th at 12:00 p.m. - 362 8th at 9:00 p.m. - 367 9th at 12:00 p.m. - 384 11th at 12:00 p.m. - 380 13th at 9:00 p.m. - 382</p> <p>Review of the clinical record from November 1, 2014 to January 14, 2015, indicated the resident had 59 episodes of elevated blood sugars which should have resulted in physician notification with 11 of them being greater than 400 and requiring additional monitoring.</p> <p>Review of the clinical record from November 1, 2014 to January 14, 2015, lacked an indication of the blood sugars being obtained on the following dates and times: November, 2014 at 11:00 a.m.: 4, 11 November, 2014 at 11:00 p.m.: 4, 5, 7, 8, 9, 14, 17, 19, 21, 25, 30 December, 2014 at 11:00 p.m.: 5, 7, 11, 13, 15, 17, 18, 19, 20, 21, 24, 26, 29, 31 January, 2015 at 11:00 a.m.: 1 January, 2015 at 11:00 p.m.: 4, 6, 12, 13</p> <p>This resulted in 32 blood sugar checks not obtained and no documentation of the resident refusing to allow the blood sugar to be checked.</p> <p>Resident #45's record indicated the resident received 6 units of Novolog</p>						

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	<p>sliding scale insulin for a blood sugar of 289 on 12/12/14 at 4:00 p.m. The resident should have received 4 units.</p> <p>Resident #45's record indicated the resident received 4 units of Novolog sliding scale insulin for a blood sugar of 323 on 12/24/14 at 8:00 p.m. The resident should have received 6 units. No reason was documented for the wrong dose being given.</p> <p>The resident's blood sugar was 331 on 12/26/14 at 6:00 a.m. and the record lacked an indication of the sliding scale insulin being administered.</p> <p>The record indicated the resident's blood sugar was 301 at 6:00 a.m. on 1/1/15 and there was no indication of the resident receiving sliding scale insulin and no indication of the resident refusing her insulin.</p> <p>Resident #45 had a blood sugar of 392 at 4:00 p.m. on 1/4/15 and received 4 units of sliding scale insulin. She should have received 6 units.</p> <p>Resident #45 had a blood sugar of 269 at 6:00 a.m. on 1/5/15 at 6:00 a.m. and was given 2 units of Novolog sliding scale insulin. She should have received 4 units of Novolog insulin.</p>			

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	<p>The resident's blood sugar was 252 at 9 p.m. on 1/5/15 and 2 units of Novolog sliding scale insulin was given instead of 4 units.</p> <p>Resident #45's blood sugar was 310 at 9:00 p.m. at 1/6/15. The resident was given 4 units of Novolog insulin and she should have received 6 units.</p> <p>This resulted in the resident receiving the wrong sliding scale coverage 8 times from November 1, 2014 to January 14, 2015.</p> <p>1.B. Resident #45 had a physician's order for digoxin 125 mcg tablet 1 tablet by mouth every other day for dysrhythmia. Hold if heart rate less than 60 and notify MD. This order originated 8/14/14.</p> <p>Review of the clinical record from November 1, 2014 to January 14, 2015, lacked an indication of the resident's pulse being taken when the medication was given on the following dates: November, 2014: 13, 19, 21, 23, 25, 27 December, 2014: 3, 5, 19, 27, 27, 29, 31</p> <p>On 1/16/15 at 9:30 a.m., additional information was requested from the RN Consultant and the Director of Nursing related to the missing blood sugar tests,</p>			

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	<p>the high blood sugars and follow up, wrong insulin doses given, and missing pulses.</p> <p>No additional information was provided at time of exit on 1/16/15 at 3:54 p.m.</p> <p>2. The clinical record for Resident #40 was reviewed on 1/14/15 at 10:29 a.m. Diagnoses for Resident #40 included, but was not limited to, hypertension, diabetes, and schizoaffective disorder.</p> <p>A health care plan problem, dated 7/1/13, indicated Resident #40 had a diagnosis of hypertension. Interventions for this problem included, but were not limited to, monitor blood pressure and administer medications as ordered.</p> <p>Resident #40 had current physician orders for the following:</p> <p>a. Diovan (a blood pressure medication) 160 milligrams (mg), 1 tablet by mouth every morning. Hold if the blood pressure is less than 100/60. The original date of this order was 6/2/14.</p> <p>b. Clonidine (a blood pressure medication) 0.1 mg patch. Apply 1 patch topically and change the patch every 7 days on Saturday. The original date of the order was 2/28/12.</p>			

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	<p>c. Hydrochlorothiazide (a blood pressure medication) 25 mg, 1 tablet by mouth every day. The original date of the order was 8/10/12.</p> <p>The December 2015 Medication Administration Record (MAR) lacked a blood pressure on 12/1/14, 12/2/14, 12/6/14, 12/10/14, 2/13/14, 12/14/14, and 12/28/14.</p> <p>During an interview with the Director of Nursing on 1/16/15 at 10:28 a.m., additional information was requested related to the lack of blood pressure monitoring on 12/1/14, 12/2/14, 12/6/14, 12/10/14, 2/13/14, 12/14/14, and 12/28/14. On 1/16/15 at the time of exit, no information regarding blood pressure monitoring for Resident #40's had been provided by the facility.</p> <p>3. A current, 10/2014, facility policy titled, "Charting and Documentation", which was provided by the RN Consultant on 1/16/15 at 2:45 p.m., indicated the following:</p> <p>"Nurses must record the following factors, including but not limited to: ...change on vital signs: blood pressure, temperature, pulse and respiration. ...3. The Nursing narrative notes are to reflect:</p>						

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F000356 SS=C	<p>Care provided and response to care, ...Signs and symptoms... Attempts to notify physicians, whether successful or not, and the results of notification."</p> <p>A current, 10/2014, facility policy titled "Hyperglycemia Treatment, which was provided by the RN Consultant on 1/15/15 at 9:30 a.m., indicated the following:</p> <p>"Purpose: Appropriate nursing care is provided to residents with Diabetes Mellitus who require insulin or oral hypoglycemic agents to minimize the risk of, and to ensure prompt recognition of, hyperglycemia.</p> <p>...If blood glucose is above the high end of normal range, notify physician as soon as possible for subsequent care orders... Monitor resident frequently for the remainder of the shift. Notify oncoming shift of any concerns... 6. Document pertinent observations in the clinical record."</p> <p>3.1-35(g)(2) 3.1-35(g)(1)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION</p>						

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	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the list of "nursing staff on duty" was posted and updated on a daily basis as required. This had the potential to effect 45 of 45 residents who resided in the facility.</p> <p>Findings include:</p>	F000356	<p>F 356</p> <ol style="list-style-type: none"> 1.No residents were affected. Staff werere-educated to the proper procedure to ensure the information on the Nursingstaffing information posting is accurate, updated and posted daily. 2.Staff were re-educated to the proper procedueto ensure the information on the Nursing 	02/15/2015

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	<p>During the initial tour of the facility on 1/12/15, at 8:38 a.m., the "nursing staff on duty" posting was observed on the wall near the Admissions office and front entrance. The posting was dated 1/9/15.</p> <p>During an interview with the Director of Nursing on 1/16/15, at 10:28 a.m., she indicated the "Front Nurse" was responsible for changing the "nursing staff on duty" on Saturdays and Sundays. She further indicated the list of "nursing staff on duty" should have been updated daily including the weekends.</p> <p>Review of the current facility policy, dated 10/2014, titled "POSTING OF DAILY NURSING STAFFING HOURS", provided by the RN Consultant on 1/16/15, at 10:36 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure that personnel and visitors have access to the actual number of hours worked by licensed and non-licensed personnel daily.</p> <p>POLICY: Facility personnel will ensure daily posting of the total numbers of actual hours worked by licensed and non-licensed nursing personnel directly responsible for resident care per shift...."</p>		<p>staffing information posting is accurate, updated and posted daily.</p> <p>3.To ensure ongoing compliance concerning posted nurse staffing information is accurate, updated and posted daily, Staff were re-educated on the proper procedure for posting. The DON and/or her designee will monitor the nurse staffing data to assure information is complete, accurate and posted daily 5 xs/ week on scheduled work days. Should concerns be noted, corrective action will be taken. The "front" charge nurse will monitor and update the nurse staffing information to assure it is accurate on the weekends and report to the DON and/or Designee results.</p> <p>4.As a means of quality assurance, the DON and /or designee will report the findings of the monitoring and any corrective actions to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5.2-15-15</p>		

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F000371 SS=E	<p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 pantry refrigerators were free of spills, ice build up and contained thermometers. This deficient had the potential to effect 31 of 45 residents living at the facility.</p> <p>Findings include:</p> <p>The refrigerator in the pantry for the front nurses station was observed on 1/16/15 at 2:40 p.m., with the Assistant Director of Nursing present. There were multiple dried spills on all the shelves and the freezer section had no thermometer in it.</p> <p>The refrigerator in the pantry for the back nurses station was observed on 1/16/15 at 2:45 p.m., with the Assistant Director of Nursing. The refrigerator had dried spills on the shelves. The freezer had a thick layer of ice build up. There was no thermometer in the freezer section. The</p>	F000371	<p>F 371</p> <p>1.NO residents were harmed. The refrigerators were cleaned immediately and thermometers were placed inside to monitor temperatures. The Nursing staff was re-educated about the importance of cleaning and monitoring the temperatures of the pantry refrigerators. The Night shift cleaning schedule was updated as necessary to assure follow through of the cleaning and monitoring of refrigerator temperatures.</p> <p>2.All residents have the potential to be affected. The Nursing staff was re-educated about the importance of cleaning and monitoring the temperatures of the pantry refrigerators. The Night shift cleaning schedule was updated as necessary to assure follow through of the cleaning and monitoring of refrigerator temperatures.</p> <p>3.To ensure ongoing compliance concerning the cleanliness and monitoring</p>	02/15/2015

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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES				STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012			
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F000514 SS=D	<p>Assistant Director of Nursing indicated she thought it was housekeeping's job to clean the refrigerators.</p> <p>During an interview with the RN Consultant on 1/16/15 at 2:49 p.m., she indicated it was the 3rd shift Nurse's job to clean the refrigerators.</p> <p>During an interview with the Director of Nursing on 1/16/15 at 3:00 p.m., she indicated not all of the residents used the refrigerators in the pantries. She indicated there were residents on each hall with refrigerators in their rooms. She indicated 31 of 45 residents used the pantry refrigerator.</p> <p>3.1-21(i)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCES SIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>		<p>temperatures of the pantry refrigerators, The Administrator and/or designee will monitor both pantry refrigerators 5 x/week x 1 month, 3 x/ week x 1 month, then weekly thereafter to assure cleanliness and monitoring of temperatures. Should concerns be noted, corrective action will be taken.</p> <p>4. As a means of quality assurance, the Administrator will report the findings of the monitoring and any corrective actions to the QA committee monthly x 3 months then quarterly thereafter, and revisions to the plan, if warranted.</p> <p>5.2-15-15</p>				

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	<p>Based on interview and record review, the facility failed to ensure vital signs monitoring and blood sugar monitoring were accurately documented in the resident's clinical records for 2 of 23 residents reviewed for accurate clinical records. (Resident #40 and Resident #45)</p> <p>Findings include:</p> <p>1. Resident #45's clinical record was reviewed on 1/14/2015 at 12:40 p.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus, hypertension, coronary artery disease, history of mitral valve prolapse, and congestive heart failure.</p> <p>The resident had an order for the blood pressure to be checked on Tuesdays. This order originated on 9/26/12.</p> <p>The clinical record lacked an indication of the blood pressure being obtained on the following dates: November, 2014: 25 December, 2014: 2, 30 January, 2015: 6, 13</p> <p>During an interview with the Director of Nursing on 1/15/15 at 10:00 a.m., she provided a blood pressure taken on 1/2/15 of 133/82.</p>	F000514	<p>F 514</p> <p>1. Resident 45 physician was notified regarding the missing Blood Pressures. No new orders obtained at this time. RN # 4 was re-educated on the proper procedure for documenting of blood pressures. Resident # 40 physician was notified concerning the missing blood sugar values. The Director of Nursing was educated on, and will monitor documentation to assure integrity of the information of the chart as noted below.</p> <p>2. A chart review was conducted for all other residents receiving sliding scale insulin coverage, as well as monitoring of pulse and blood pressures for therapeutic drugs. Physicians notified of any further abnormalities. All licensed nursing staff were re-educated on the policy and procedure regarding Charting and Documentation including but not limited to: blood glucose monitoring, hyper/hypoglycemic reactions, monitoring of pulse and blood pressure for therapeutic medications, and proper documentation of the above.</p> <p>3. As a means to ensure compliance with proper documentation of blood sugars per sliding scale, monitoring of pulse and Blood pressure per physicians orders for therapeutic medications, All licensed nursing staff were re-educated on the policy and procedure regarding</p>	02/15/2015			

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	<p>During an interview with RN #4 on 1/16/15 at 10:58 a.m., she indicated she records blood pressures in her personal notebook when she takes them and sometimes forgets to document them in the resident's record.</p> <p>On 1/16/15 at 9:30 a.m., additional information was requested from the RN Consultant and the Director of Nursing related to the missing blood pressures.</p> <p>No additional information was provided at time of exit on 1/16/15 at 3:54 p.m.</p> <p>2. The clinical record for Resident #40 was reviewed on 1/14/15 at 10:29 a.m. Diagnoses for Resident #40 included, but was not limited to, hypertension, diabetes, and schizoaffective disorder.</p> <p>The November 2014 "BLOOD GLUCOSE MONITORING SLIDING SCALE INSULIN RECORD", was missing the following blood glucose results:</p> <p>November 1, at 12:00 p.m. November 2, at 12:00 p.m. November 3, at 9:00 p.m. November 7, at 5:00 p.m. November 7, at 9:00 p.m. November 12, at 9:00 p.m. November 16, at 12:00 p.m.</p>		<p>Charting and Documentation including but not limited to: blood glucose monitoring, hyper/hypoglycemic reactions, monitoring of pulse and blood pressure for therapeutic medications, and proper documentation of the above, The DON and other designee will monitor resident care records 5x/week x 1 month, 3 x/week x 1 month, then weekly thereafter, should concerns be noted, corrective actions shall be taken.</p> <p>4. As a means of quality assurance, the DON and/or other designee will report the findings of the above reviews and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5.2-15-15</p>	

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	<p>November 19, at 4:00 p.m. November 19, at 9:00 p.m. November 21, at 9:00 p.m. November 30, at 6:00 a.m. November 30, at 12:00 p.m. A total of 12 missing blood glucose results.</p> <p>During an interview with the Director of Nursing on 1/15/15 at 2:54 p.m., additional information was requested related to the lack of blood glucose results. Copies of the November, 2014, and December 2014, "BLOOD GLUCOSE MONITORING SLIDING SCALE INSULIN RECORD", for Resident #40.</p> <p>Copies of the November, 2014, and December 2014, "BLOOD GLUCOSE MONITORING SLIDING SCALE INSULIN RECORD", for Resident #40 were provided on 1/15/15 at 3:35 p.m., by the Director of Nursing. The copy of the November, 2014, "BLOOD GLUCOSE MONITORING SLIDING SCALE INSULIN RECORD" was complete and without any missing blood glucose results.</p> <p>During an interview with Director of Nursing and the RN Consultant on 1/16/15 at 10:28 a.m., the Director of Nursing indicated she did not know</p>			

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	<p>where the 12 missing blood glucose results from the November, 2014 "BLOOD GLUCOSE MONITORING SLIDING SCALE INSULIN RECORD" were obtained and when they were added to the record.</p> <p>3. A current, 10/2014, facility policy titled, "Charting and Documentation", which was provided by the RN Consultant on 1/16/15 at 2:45 p.m., indicated the following:</p> <p>"Nurses must record the following factors, including but not limited to: ...change on vital signs: blood pressure, temperature, pulse and respiration. ...3. The Nursing narrative notes are to reflect: Care provided and response to care, ...Signs and symptoms... Attempts to notify physicians, whether successful or not, and the results of notification."</p> <p>A current, 10/2014, facility policy titled "Hyperglycemia Treatment, which was provided by the RN Consultant on 1/15/15 at 9:30 a.m., indicated the following:</p> <p>"Purpose: Appropriate nursing care is provided to residents with Diabetes Mellitus who require insulin or oral</p>						

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	<p>hypoglycemic agents to minimize the risk of, and to ensure prompt recognition of, hyperglycemia.</p> <p>...If blood glucose is above the high end of normal range, notify physician as soon as possible for subsequent care orders... Monitor resident frequently for the remainder of the shift. Notify oncoming shift of any concerns.</p> <p>6. Document pertinent observations in the clinical record."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						