

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  11/02/2011
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NAME OF PROVIDER OR SUPPLIER  MEADOW VIEW HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
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F0000	<p>This visit was for Investigation of Complaints IN00099173 and IN00097596.</p> <p>Complaint IN00099173 - Substantiated. Federal/state deficiencies related to the allegations are cited at F514.</p> <p>Complaint IN00097596 - Substantiated. Federal/state deficiencies related to the allegations are cited at F241 and F332.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: 10/26/11, 11/1/11, and 11/2/11</p> <p>Facility number: 000218 Provider number: 155325 AIM number: 100274800</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF: 1 SNF/NF: 95 Total: 96</p> <p>Census payor type: Medicare: 12 Medicaid: 72</p>	F0000	<p>Submission of the Plan of Correction does not constitute an admission by this facility of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted, as required by law. We respectfully request this Plan of Correction serve as our allegation of compliance date being 2 December 2011.</p>	

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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	<p>Other: 12 Total: 96</p> <p>Sample: 19</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/07/11 by Suzanne Williams, RN</p>						

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F0223 SS=A	<p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was not verbally abused by staff for 1 of 3 residents reviewed related to allegations of abuse in a sample of 19. (Resident R)</p> <p>Findings include:</p> <p>The employee file for CNA #6 was reviewed on 11/1/11 at 2:55 p.m. The "Employee Separation Report" indicated CNA #6 was hired on 2/10/10, was terminated on 9/6/11, was discharged for a "Resident Rights Violation," and was not eligible for rehire. The report also indicated CNA #6's last date worked was 9/2/11.</p> <p>During interview on 11/1/11 at 3:55 p.m., the Administrator indicated CNA #6 was terminated related to an allegation of verbal abuse, because he told a resident he was a "pain in the a--." The Administrator provided copy of the "Facility Incident Reporting Forms" faxed to the Indiana State Department of Health.</p>	F0223	Was corrected at time of incident per State Reportable..	12/02/2011			

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	<p>The first form indicated, "Initial Report," and included the following: "Incident Date: September 3, 2011, Incident Time: [symbol for about] 12:05 a.m....Brief Description of Incident: CNA [CNA #8] reported that another CNA [CNA #6] told a resident 'he was a pain in the a--'... Immediate Action Taken: CNA [CNA #6] immediately suspended pending verbal abuse allegation. Preventive measures taken: Resident reassured and will continue to monitor."</p> <p>The second form indicated, "Follow-up Report" and included the following additional information: "Follow Up: Statements were reviewed and spoke to [name of CNA #6] and he states he did tell the resident that he was a 'pain in the a--' which he indicated that the statement was made in reference to the other residents. At that time I informed employee that I had no other recourse but to terminate his employment for verable [sic] abuse."</p> <p>During the Exit Conference completed on 11/2/11 at 6:45 p.m., the Administrator indicated she had located the file related to the investigation of the allegation of verbal abuse. Review of the file indicated CNA #8 reported the allegation immediately to his supervisor, the information was reported immediately up</p>			
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	<p>the chain of command, CNA #6 was suspended immediately for the duration of investigation, and CNA #6 was subsequently terminated.</p> <p>3.1-27(b)</p>				

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F0241 SS=E	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were allowed to rest in bed instead of lined up in the hallway seated upright in wheel chairs with eyes closed and heads drooping forward while awaiting the breakfast meal for 6 of 6 residents reviewed related to dignified care in a sample of 19. (Residents J, K, L, M, N, and P)</p> <p>Findings include:</p> <p>During the Initial Tour on the North Hall - Left on 10/26/11 at 5:25 a.m. with the Director of Nursing (DON), the following residents were observed seated in wheel chairs in a line along the wall of the hallway: Residents J, K, L, M, N, and P. During interview at this time, the DON indicated breakfast for the North Hall residents would be served at 7:30 a.m. in the Main Dining Room. Resident N was dressed in daywear, and her head was positioned down toward the chest. Resident K was dressed in daywear covered by a clothing protector, and his head was down and eyes were closed. As the resident was passed, he raised his head and opened his eyes briefly. Resident K's</p>	F0241	<p>1. Corrective action is to allow Residents to remain in bed until no earlier than 6:00 AM. Resident that are able will be interviewed by SS to see if there are any other concerns. Residents J,K,L,M,N and P did not experience any negative outcome secondary to this alledged deficient practice.2. Interview with social services indicated that no other residents to found to be affected by this alledged deficient practice.3. Measures put into place to ensure the practice does not recur. a. Inservice Staffb. Change shift times for CNA'sc. random off shift visits by DON/HFA/Designee to assure the new get up time is being followedc. Resident will not be gotten out of bed prior to 6:00AM except for when requested and or medical procedure requires earlier ADL care.3. corrective action will be monitored by Charge Nurses and will insure that Resident are not gotten out of Bed before 6:00AM unless warranted. Charge nurse will indicate compliance on 24 hour report daily for 3 months. Unit Managers/designee will verify schedules are being followed X5 weekly for 3 months and then Monthly X 3 months 4. This process will be monitored</p>		12/02/2011		

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	<p>lower lid of the left eye was red, and the DON indicated the resident usually had antibiotic eye drops for conjunctivitis. Resident K lowered his head and closed his eyes again. Resident L was dressed in daywear, and his head was down and his eyes were closed. Resident M was dressed in daywear, her eyes were closed, and she was yawning. Residents P and J were both dressed in daywear.</p> <p>During observation on the North Hall - Left on 10/26/11 at 6:35 a.m., Residents K, M, N, and P were seated in their wheel chairs along the wall of the hallway with eyes closed and heads drooping. Resident L was observed using one hand to pull himself slowly along the handrail on the other wall of the hallway. Resident J was heard asking staff to assist her to bed, because her back was hurting.</p> <p>On 11/1/11 at 4:30 p.m., Residents K, J, M, and N were observed seated in wheel chairs at a table in the Main Dining Room awaiting dinner service. During interview at this time, Resident K indicated, "No" in regard to whether he likes to get up early. Resident J indicated, "I don't think he does." When interviewed in regard to her liking to get up early, Resident J first said "Yes," and then changed her response and indicated, "No" she didn't like to get up early. Resident L's head was down on</p>		monthly during the QA process for review and up-date as indicated.				

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	<p>the table, and his eyes were closed.</p> <p>During interview on 11/1/11 at 4:00 p.m., the Assistant Dietary Manager (ADM) accessed screens in the computer of the Dietary Office and indicated Residents J, K, L, M, N, and P all required assistance with eating and took all their meals in the Main Dining Room. The ADM indicated the Main Dining Room was served breakfast at 7:30 a.m. The ADM indicated Resident K was served an "early tray" just ahead of the full service in the Main Dining Room. The ADM indicated she thought Resident K received an "early tray" because he took a little longer to eat.</p> <p>Review of the list of names of interviewable residents provided by the Social Services Assistant on 11/1/11 at 3:13 p.m., did not include the names of Residents J, K, L, M, N, and P.</p> <p>During confidential interview on 10/30/11, a former staff member indicated wondering why residents on North Hall-Left were awakened during the night for showers and put back to bed, and why residents were awakened beginning at 4:30 a.m. to get up for breakfast. The interviewee indicated this had not seemed like the best care for the residents on North Hall-Left, who needed rest.</p>			
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	<p>1. The clinical record for Resident K was reviewed on 11/1/11 at 12:30 p.m.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 10/21/11 indicated the resident usually makes himself understood and usually understands others. The assessment indicated the resident exhibited no behaviors. The assessment indicated the resident required the extensive assistance of two persons for bed mobility, transfers, and dressing, was totally dependent for bathing, and was always incontinent of bowel and bladder.</p> <p>The Cognitive Assessment/Plan of Care, most recently updated 10/21/11, included, but was not limited to "Resident is interviewable" and "Moderately impaired" in "Cognitive ability for decision making."</p> <p>The ADL (Activities of Daily Living)/Mobility: Plan of Care, most recently updated 10/20/11, included interventions of, but not limited to: Personal Hygiene/Grooming/Dressing/Undressing: Assist/encourage/provide per resident preference."</p> <p>2. The clinical record for Resident J was reviewed on 11/2/11 at 11:30 a.m.</p> <p>The quarterly MDS assessment, dated 9/22/11 indicated the resident usually makes herself understood and usually understands others. The assessment indicated the resident required the extensive assistance of two persons for bed mobility and transfers, and extensive assistance of one person for dressing and personal hygiene.</p> <p>The Comprehensive Care Plan Review Summary, dated 10/24/11, indicated the resident had no behavior issues.</p> <p>The ADL (Activities of Daily Living)/Mobility:</p>			
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	<p>Plan of Care, most recently updated 10/24/11, included interventions of, but not limited to: Personal Hygiene/Grooming/Dressing/Undressing: Assist/encourage/provide per resident preference."</p> <p>The Cognitive Assessment/Plan of Care, most recently updated 10/24/11, included, but was not limited to "Resident is interviewable" and "Moderately impaired" in "Cognitive ability for decision making."</p> <p>This federal tag relates to Complaint IN00097596.</p> <p>3.1-3(t)</p>			

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F0332 SS=D	<p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review and interview, the facility failed to ensure it was free of a medication error rate of 5% or greater, for 2 of 14 residents observed receiving medications in sample of 19 residents. (Residents G and K) Two errors in medication administration were observed during 40 opportunities for error in medication administration. This resulted in a medication error rate of 5 %.</p> <p>Findings include:</p> <p>1. During observation of the medication pass on 11/1/11 at 4:30 p.m., LPN #5 prepared medications for Resident K.</p> <p>A. Oral medications included, but were not limited to, a medication labeled, "Tamulosin 0.4 mg 1 by mouth at bedtime." LPN #5 placed the resident's crushed medications in a medication cup, opened the Tamulosin capsule, and poured the contents into the medication cup with the other medications, mixed with applesauce, and prepared to take the medications to the resident's room for administration. During interview at this time related to timing of the administration of tamulosin, LPN #5 indicated the medication was to be</p>	F0332	<p>1. Corrective action Resident G &amp; K did not experience a negative out come as a result of this alledged defective practice2. Based on facility review no other residents were found to be affected by this alledged deficent practice practice.3. Measures put into place to ensure the practice does not recur. Medication observator will be conducted on 10% of the residents weekly X 1 month then 10% monthly X 3 days at random by DON/Designee. Current Licensed Staff will educated on adminstration followed with a post test. Any New hires will required to complete the Medication Administration Training and post test. Skills completecy related to Medication pass will be completed monthly X 6 mths.4. Corrective action will be monitored by DON/Designee monthly X 6 months and this process will be reviewed by QA Committe monthly for review and updated as indicated.</p>	12/02/2011			

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	<p>administered at 5:00 p.m., as indicated on the Medication Administration Record, which she pointed to, even though the order actually said bedtime.</p> <p>LPN #5 rolled Resident K into his room in his wheel chair, administered the oral medications, including the tamulosin, and indicated she would take the resident back to the table in the Main Dining Room for supper.</p> <p>The clinical record for Resident K was reviewed on 11/1/11 at 12:30 p.m. Physician's orders for October 2011, signed by the physician on 10/24/11, included orders for medications including, but not limited to, "Flomax [tamulosin] 0.4 mg capsule, give 1 capsule orally at bedtime for BPH [benign prostatic hyperplasia]; will assist with urinary elimination." The timing for the medication on the signed orders was 5:00 p.m.</p> <p>On 11/2/11 at 4:05 p.m., the Director of Nursing (DON) provided a copy of the manufacturer's instructions for Tamulosin Hydrochloride Oral, which she indicated in interview at this time was provided by pharmacy. The DON indicated the physician's order was unclear related to timing of the tamulosin, and that no physician's order had been obtained to</p>						

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	<p>open the capsule to administer the medication to the resident. Review of the manufacturer's instructions indicated in the section for "Administration &amp; Dosage...Benign prostatic hyperplasia: Usual dosage: 0.4 mg once daily 30 minutes following the same meal each day." The section for "Patient Information," included, but was not limited to, "...Patients should be advised not to crush, chew or open the tamulosin capsules."</p> <p>2. On 11/2/11 at 11:55 a.m., LPN #7 prepared medications for administration to Resident G, including, but not limited to, a medication labeled, "Carafate 1000 mg/ml, give 5 ml orally 4 times a day." The nurse shook the medication bottle, poured the medication into a medication cup, entered Resident G's room and administered the Carafate and other medications. The medication pass was completed at 12:10 p.m.</p> <p>The clinical record for Resident G was reviewed on 11/2/11 at 3:45 p.m. Physician's Orders for November 2011 included, but were not limited to, "Carafate 1gm/10 ml susp [suspension], give 5ml (500 mg) orally 4 times a day - GERD [gastroesophageal reflux disease]." The times for administration listed on the Physician's Orders of the medication were</p>			
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	<p>6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m.</p> <p>Review of the "New Meal Service Times Effective January 16th 2009," provided by the Dietary Manager on 11/1/11 at 11:45 a.m., indicated the meal trays on Resident G's hall were scheduled to arrive at 12:20 p.m. daily.</p> <p>On 11/3/11 at 3:00 p.m., review of the package insert for Carafate on-line at <a href="http://dailymed.nlm.nih.gov">http://dailymed.nlm.nih.gov</a> included, but was not limited to, in "Dosage and Administration...Carafate should be administered on an empty stomach...."</p> <p>On 11/2/11 at 4:05 p.m., the DON provided a nursing drug handbook and indicated it was used at the nurses stations. Pages 1102-1103 indicated information for Sucralfate (Carafate) including, but not limited to, "Teaching points - Take the drug on a empty stomach, 1 hour before or two hours after a meal.</p> <p>This federal tag relates to Complaint IN00097596.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure staff washed hands and used gloves in accordance with the facility's infection control procedures</p>	F0441	<p>1. Corrective action Residents C, D, S &amp; T did not experance an negative outcome as result of the alledged difficient practice. 2. Based on facility review no other</p>		12/02/2011		

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	<p>for 4 of 14 residents observed receiving medications in a sample of 19. (Residents C, D, S, and T)</p> <p>Findings include:</p> <p>1. During observation of the medication pass on 10/26/11 at 6:05 a.m., LPN #9 returned to the medication cart after administering a medication, and without washing hands or using hand sanitizer, and prepared an insulin injection for Resident C. LPN #9 carried the insulin syringe and supplies for a blood sugar check into Resident C's room and placed them on the overbed table. LPN #9 removed the resident's CPAP (continuous positive airway pressure) mask from his face. Without washing hands/using hand sanitizer, and without donning gloves, LPN #9 completed the blood sugar test. Without washing hands/using hand sanitizer, LPN #9 donned gloves, administered the insulin, removed the gloves, and without washing the hands/using hand sanitizer returned to the medication cart to prepare Resident C's sliding scale insulin. LPN #9 prepared the insulin, returned to the room, donned gloves, administered the sliding scale insulin, and removed the gloves without washing hands or using hand sanitizer.</p> <p>2. During observation on 10/26/11 at 6:20</p>		<p>residents to found to be affected by this alleged deficient practice.3. Measures have been put into place and staff inservice will be completed to ensure the practice does not recur. Observation of resident receiving Insulin and Accuchecks will be completed by the DON/Designee daily X 1 week then weekly X 1 month to assure staff is washing and/or using hand sanitizer after each residents care occurs. Staff will educated on Hand Washing and using gloves per policy. Skills validation will be completed on staff to assure understanding of Hand Washing, Sanitizer and use of gloves. 4. Corrective action will be monitored by the process stated above and will be monitored by the QA committe montly for review and follow-up of above measures.</p>				

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	<p>a.m., after completing the medication pass to Resident C, and without washing hands or using hand sanitizer, LPN #9 began to prepare medications for Resident D. LPN #9 entered Resident D's room and administered the medications.</p> <p>3. During observation of the medication pass on 11/1/11 at 4:30 p.m., LPN #5 returned to the medication cart after administering a medication. Without washing hands or using hand sanitizer, LPN #5 moved supplies to the top of another medication cart and began to prepare medications for Resident T from the second cart. LPN #5 entered Resident T's room and administered the medications.</p> <p>4. During observation of the medication pass on 11/2/11 at 11:40 a.m., LPN #7 washed her hands. Before she began to prepare medications for Resident S, another resident requested assistance for bed to wheel chair transfer. LPN #7 provided transfer assistance, and then patted the resident on the back as she left the room. Without washing her hands or using hand sanitizer, she prepared and administered medication to Resident S.</p> <p>Review of the facility's procedure for "Hand Hygiene - Plain Soap and Water Handwash," found placed on the</p>			

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	<p>Conference Room table on 11/2/11 at 2:00 p.m., included, but was not limited to, "Hand hygiene is the most important procedure for preventing Healthcare Associated Infections....A plain soap and water handwash or an alcohol hand rub may also be used: ...Before having direct contact with residents...After contact with a resident's intact skin...After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident...After removing gloves...."</p> <p>3.1-18(l)</p>			