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 01/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW BROOK REHABILITATION CENTRE & SUITES	1821 LINDBERG RD ANDERSON, IN 46012

(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
F000000	This visit was for the Investigation of Complaints IN00142172 and IN00143087. Complaint IN00142172 - Substantiated with findings at F257 and F465. Complaint IN00143087 - Substantiated with findings at F257, F309, and F514. Survey Dates: 1/24, and 27/14 Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180 Surveyor: Betty Retherford RN Census Bed Type: SNF/NF: 49 SNF: 10 Total: 59 Census Payor Type: Medicare: 10 Medicaid: 42 Other: 7 Total: 59 Sample: 7	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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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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	These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.			
F000257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation, interview, and record review, the facility failed to provide comfortable temperatures for 4 of 7 residents reviewed for comfortable room temperatures in a sample of 7. (Resident #'s F, C, E, and G) Findings include: During a review of resident room temperatures, taken by the Maintenance Director on the morning of 1/24/14, provided by the Administrator on 1/24/14 at 2:05 p.m., they included, but were not limited to the following low room temperature readings taken that morning: Room 104: 65 degrees (Resident	F000257		02/25/2014

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	#F) Room 109: 65 degrees (Resident #E) Room 116: 65 degrees (Resident #G) Room 119: 64 degrees (Resident #C) During a review of an "Interviewable List", provided by the Administrator on 1/24/14 at 10:15 a.m., the list indicated Residents #E, G, and C were alert, oriented, and able to provide reliable information. A Quarterly Minimum Data Set assessment, dated 11/8/13, indicated Resident #F had mild cognitive impairment, but was able to understand others and be understood by others. The Administrator was interviewed on 1/24/14 at 2:00 p.m., additional information was requested related to the low temperature readings recorded by the Maintenance Director on the temperature logs earlier that morning. The Administrator indicated she was unaware of any temperature readings below 70 degrees that had been taken that morning. During an environmental tour,		Windows were properly secured for residents E, F, and G. Resident C was relocated per personal request to a room on another hallway.	

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NAME OF PROVIDER OR SUPPLIER: MEADOW BROOK REHABILITATION CENTRE & SUITES

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	conducted with the Administrator and Maintenance Director on 1/24/14 at 2:05 p.m., the following room temperature readings and interviews were completed: Room 104 - temperature 69 degrees. Resident #F complained of his room being too cool. He indicated he sometimes he went to bed to get warm. The Maintenance Director checked the windows in the resident's room and indicated they had not been closed in the proper manner. The Maintenance Director closed the windows properly and indicated the room should get warmer. Room 109 - temperature 65 degrees. Resident #E indicated her room was too cool. The resident was seated in her chair with a sweatshirt on and a blanket across her lap. The Maintenance Director checked the windows in the resident's room and indicated they had not been closed in the proper manner. The Maintenance Director closed the windows properly and indicated the room should get warmer. Room 116 - temperature 67 degrees. Resident #G indicated her		All residents have the potential to be affected. An audit was conducted by Maintenance personnel to ensure all resident windows were secured properly. Three residents were identified as requesting that their windows remain open to allow fresh air. Additionally an audit was conducted of all floor vents (register covers) to ensure that they are in proper working order. Vents that were identified as	

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	room was too cool. She indicated she would like for her room to be warmer. The Maintenance Director checked the windows in the resident's room and indicated they had not been closed in the proper manner. The Maintenance Director closed the windows properly and indicated the room should get warmer. Resident #C was interviewed on 1/27/14 at 11:15 a.m. She indicated her room temperature was too cool. The room temperature was 71.2 degrees near the register on the floor beneath the windows. The resident had blankets on the ledge underneath her windows. The register was observed to be rusted and was almost in a closed position. The register could not be opened to allow more heat into the room. The Administrator was interviewed on 1/27/14 at 11:30 a.m. Concerns were expressed related to the rusted register in Resident #C's room that could not be opened wider. The Administrator indicated she would arrange for the register to be replaced. The Administrator was interviewed on 1/27/14 at 4 p.m. She indicated		non-working will be replaced to ensure that residents who have the ability to open or close their own vents may do so. Facility Maintenance personnel will conduct weekly audits of all resident rooms for 2 weeks, then weekly audits of no less than 50% of rooms on each hallway for 6 weeks. Temperatures below 71	

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	the rusted register for Resident #C had been replaced with one that could easily be opened and adjusted. Resident #F was interviewed on 1/27/14 at 11:00 a.m. Resident #F indicated his room was much warmer since the window had been shut properly on 1/24/14. He indicated he no longer needed to go back to bed to get warm. Resident #E was interviewed on 1/27/14 at 11:05 a.m. She was up in her room watching television. She was wearing a long sleeved shirt. She indicated her room was much warmer since the window had been shut properly on 1/24/14. This federal tag relates to Complaints IN00142172 and IN00143087. 3.1-19(h)		degrees and/or above 81 degrees will be reported immediately to the Administrator or their designee. Results of aforementioned	

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			ongoing monitoring and any corrective actions taken will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.	

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F000309 SS=D	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. Based on observation, record review, and interview, the facility	F000309		02/25/2014

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	failed to ensure treatments were provided as ordered by the physician for 1 of 3 residents reviewed for treatment administration in a sample of 7. (Resident #C) Findings include: The clinical record for Resident #C was reviewed on 1/24/14 at 1:20 p.m. Diagnoses for Resident #C included, but were not limited to, Parkinson's disease, diabetes mellitus, and small cell lung cancer with radiation. A Significant Change Minimum Data Set assessment, dated 1/8/14, indicated the resident was cognitively intact. The clinical record indicated the resident was currently receiving radiation treatments for lung cancer 5 days a week. A physician's order, dated 1/15/14, indicated the resident was to have Elta Lite cream (a moisturizing protectant cream) to the red radiation areas three times daily due to her need for radiation treatments. A health care plan problem, dated 1/15/14, indicated the resident had radiation burn areas on her right mid		Resident C incurred no negative outcome. The	

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	back. One of the approaches for this problem was to apply "treatment as ordered." Resident #C was interviewed on 1/27/14 at 11:15 a.m. She indicated she had not received the Elta Lite cream treatment consistently over the weekend. She lifted her gown so the areas on her back could be viewed. She had a slightly reddened area on the right mid back. The area was intact and not open. During a review of the Treatment Administration Records for January 2014, the Elta Lite treatment was to be completed three times daily (once on each shift) The treatment was not documented as having been completed as ordered on the following dates and shifts: 1/24/14 - 10 p.m. to 6 a.m. shift 1/25/14 - 6 a.m. to 2 p.m. shift and the 2 p.m. to 10 p.m. shift 1/27/14 - 2 p.m. to 10 p.m. shift All of the noted areas on the form were left blank. The Administrator, DoN, and Nurse Consultant were interviewed on 1/27/14 at 1:45 p.m. Additional information was requested related to			

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	the Elta Lite treatment not having been completed as ordered. The Nurse Consultant was interviewed on 1/27/14 at 3 p.m. She indicated she was unable to provide any information related to the lack of documentation of the Elta Lite treatment having been done on the noted dates. Review of the current facility policy, revised 8/10, titled "Medication Administration Policy and Procedure", provided by the Administrator on 1/27/14 at 3 p.m., included, but was not limited to, the following: "Purpose: To administer medications according to the guidelines set forth by the State and Federal regulations. Procedure: ...23. Medication administration will be recorded on the MAR or TAR after given...." This Federal tag relates to Complaint IN00143087. 3.1-37(a)		clinical record for this resident has been reviewed to identify staff	

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			responsible to perform treatments on dates in question. Said staff will be	

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			addressed, as applicable.All residents who have orders for treatments	

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			have the potential to be affected. The clinical records for all residents in	

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			the facility have been reviewed to confirm that treatments have been completed	

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			as ordered. Should concerns be noted, applicable staff shall be addressed, as	

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			well as residents assessed for any potential negative outcome and corrective	

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			action taken as warranted.The facility policy and procedure for medication/treatment	

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			administration has been reviewed and no revisions were made. (See	

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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

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 01/27/2014

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			Attachment) The staff has been	

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			re-educated on the policy and procedure. The DON or her designee will observe 5 residents	

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			to ensure treatments are completed as ordered on scheduled days of work daily	

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			for two weeks, three times a week for two weeks and then weekly until compliance	

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			is maintained for 6 consecutive months. (See Attachment)Should concerns be observed, re-education	

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			will be provided. The results of said observations and any corrective actions	

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			taken will be discussed during the facility's quarterly QA meetings and the	

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			plan adjusted accordingly, if warranted.	

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F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the facility was free from roof leaks, water damage, and	F000465		02/25/2014

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	mold-like buildup for 2 of 6 halls in the facility reviewed for environmental concerns. Findings include: During an environmental tour, conducted with the Maintenance Director, Administrator, and Regional Director, on 1/24/14 at 2:05 p.m., the following concerns were noted on the 200 and 300 halls: 1. Room 216: The Administrator indicated there had been a water leak in the room and the resident residing in that room had been moved to another room. There had been a leak in the ceiling of the room along the center tracts to which the privacy curtains had been attached. Slight water discoloration was noted along the tracts. The Maintenance Director indicated the ceiling had leaked due to high wind and blowing snow from an "over-hang" area in the roof. He indicated the area would be fixed when the weather was better and he had time to get to it. 2. Hallway outside of rooms 303 to 305. There were three large water		The previous resident in room #216 had been relocated to a different room when the water leak occurred. The residents who had resided in room #302 were relocated when the wallpaper began to peel and it was discovered that there was black substance on	

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	stains in the ceiling between these 3 rooms. There were three areas of patched drywall along the upper wall in this area. The Maintenance Director indicated the ceiling had leaked due to pin hole leaks in a water line above the ceiling. He indicated this water line was very old and had a history of frequent pin hole leaks. He indicated the current pin hole leak had been fixed, but he had not yet been able to finish the drywall work and ceiling work. He indicated the entire water line on the 300 hall was due to be replaced. The Administrator indicated "Corporate" had given approval for a new water line on the 300 hall but the timeline had not yet been set. 3. Room 302 - There was black mold-like substance on an area of exposed drywall approximately 3 feet in height and 5 feet in length. This was located in a resident's room to the right as you enter the room. The other side of this wall contained the bathtub in the bathroom which also had a sprinkler head located above it in the ceiling. The administrator indicated this had		the wall. Additionally room #302 was locked by Maintenance so that it was not and is not accessible to residents, guests or staff while repairs are being made. All residents have the potential to	

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	been found approximately two months ago when wallpaper over the area began to peel. The resident had been relocated on the same day to another room and the room was kept locked until the bathroom could be "gutted" and the drywall repaired. The Maintenance Supervisor indicated he did not know where the moisture had originated. He felt there could have been another pin hole leak that had done some damage. He indicated he had not had the time to fix the area due to the harsh winter and his time having to be managed elsewhere. During an observation on 1/27/14 at 2:25 p.m., the following was noted: Another pin hole leak had occurred on the 300 hall in the center of the hall between rooms 303 and 304. A small area in the hall ceiling had cracked and allowed drips of water to drop to the floor. A towel had been placed on the floor to collect the moisture. The leak was not observed to drip at this time. The 300 hall ceiling was also observed to have numerous other cracks where it appeared a leak had occurred and the area had been patched and repainted.		be affected. An audit of all resident rooms was conducted and no other areas were identified at this time. Repairs have been made to the following areas:	

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	During an observation with the Administrator on 1/27/13 at 2:40 p.m., the following concerns were noted in the bathroom of room 210. A section of cove base had been removed from the wall beside the toilet that was approximately 4 inches in height and 18 inches long. The exposed drywall underneath had multiple areas of black mold-like substance on it. Cool air was also noted from the area where the drywall did not completely touch the floor. The Administrator indicated the drywall had been damaged over the previous weekend by a frozen water pipe. She indicated the resident was not currently using this bathroom. During an observation with the Administrator and Maintenance Director on 1/27/14 at 2:45 p.m., the following concerns were noted in room 211. An area of black mold-like substance was noted that was approximately 3 feet by 3 feet on an area of exposed drywall. Another section of drywall, approximately 2 feet tall and 7 feet long had been removed from the walls in the room. Drywall had been		Room #210- Two areas in the closet measuring approximately 29”X20” and 23”X20” have had the drywall replaced. One area in the sleeping area approximately 29.5”X73” has had the drywall replaced.	

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	removed approximately 18 inches up from the floor around all of the adjacent bathroom walls. The Maintenance Director indicated there had been water damage on 1/24/14 around 11:30 p.m., when the water pipe to an exterior water spicket had frozen. He indicated no resident had resided in this room when the leak occurred and the room remained locked at this time. He indicated it would remain locked until he was able to complete repairs. The Maintenance Director was interviewed on 1/27/14 at 2:50 p.m. regarding the new leak in the 300 hall ceiling. He indicated another small pin hole leak had occurred. He indicated he had repaired the small leak and would repair the ceiling when he had time. This federal tag relates to Complaint IN00142172. 3.1-19(f)		An area in the bathroom approximately 57”X22” has had the drywall replaced. Room #211- An area in the closet approximately 18”X25” has had the drywall replaced.	

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			Three areas in the bathroom measuring approximately 55”X16”, 57”X16” and 55”X16” have had the drywall replaced.	
			Two areas in the	

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			sleeping area approximately 80”X29” and 69”X29” have had the drywall replaced. Room #302- One area approximately 42”X29” has had the drywall replaced.	

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			300 Hallway- Multiple areas along the 300 hall have had the drywall/ceiling repaired. During	

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			the monitoring of room temperatures for F257, the Maintenance personnel will conduct a visual inspection of resident rooms and bathrooms for any water damage. Any areas of question will	

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			be reported to the Administrator or their designee immediately. Results of aforementioned ongoing monitoring and any corrective actions taken will be discussed during the facility's	

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			quarterly QA meetings and the plan adjusted accordingly, as warranted.	
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on record review and interview, the facility failed to ensure the nursing staff correctly documented why a treatment was	F000514		02/25/2014

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	not provided as ordered for 1 of 3 residents reviewed for treatment documentation in a sample of 7. (Resident #C) Findings include: The clinical record for Resident #C was reviewed on 1/24/14 at 1:20 p.m. Diagnoses for Resident #C included, but were not limited to, Parkinson's disease, diabetes mellitus, and small cell lung cancer with radiation. The Treatment Administration Record (TAR) for January 2014 for Resident #C was reviewed and the following was noted: 1. Treatment order: Apply garamycin ointment two times daily to the left lower extremity. The date of the order was 1/9/14. The TAR indicated the treatment was to be done on the 6-2 and 2-10 shifts. The staff initials were circled in the treatment boxes on 8 occasions without any explanation on the back of the record as to why the treatment was not given. 2. Treatment order: Apply nystatin cream three times daily to the		Resident C incurred no negative outcome. The	

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	abdominal folds. The date of the order was 1/8/14. The TAR indicated the treatment was to be done on the 6-2, 2-10 and 10-6 shifts. The staff initials were circled in the treatment boxes on 7 occasions without any explanation on the back of the record as to why the treatment was not given. 3. Treatment order: Apply betamethasone cream topically twice daily to lower legs, rub in well. The original date of this order was 11/19/13. The TAR indicated the treatment was to be done on the 6-2 and 2-10 shifts. The staff initials were circled in the treatment boxes on 9 occasions without any explanation on the back of the record as to why the treatment was not given. The Administrator, DoN, and Nurse Consultant were interviewed on 1/27/14 at 1:45 p.m. Additional information was requested related to the treatments having been "circled" on the previously noted dates and shifts without any documentation of why the treatment was not completed. The Nurse Consultant and DoN were interviewed on 1/27/14 at 3		clinical record for this resident has been reviewed to identify staff responsible to perform treatments on dates in question. Said staff will be	

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	p.m. The DoN indicated the staff were to circle any treatments not given and then document the reason why it was not completed on the back of the treatment record. Review of the current facility policy, revised 8/10, titled "Medication Administration Policy and Procedure", provided by the Administrator on 1/27/14 at 3 p.m., included, but was not limited to, the following: "Purpose: To administer medications according to the guidelines set forth by the State and Federal regulations. Procedure: ...10. Refusal of medications will be identified by circling the nurses or QMA's initials and documenting on the back of the MAR/TAR the date, time and reason, if known...." This Federal tag relates to Complaint IN00143087. 3.1-50(a)(1) 3.1-50(a)(2)		addressed, as applicable.All residents who have orders for treatments have the potential to be affected. The clinical records for all residents in	

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			the facility have been reviewed to confirm documentation is complete and accurate. Should concerns be noted, applicable staff shall be addressed, as	

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			well as residents assessed for any potential negative outcome and corrective	
			action taken as warranted.The facility policy and procedure for Refusal of	
			Medications has been reviewed	

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			and no revisions were made. (See Attachment) The staff has been re-educated on the policy and procedure.The DON or her designee will observe the treatment record of 5 residents to ensure the records are complete and accurate	

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			on scheduled days of work daily for 2 weeks, three times a week for two weeks and then weekly until compliance is maintained for 6 consecutive months. (See	

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			Attachment) Should concerns be observed, re-education will be provided. The results of said observations and	

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			any corrective actions taken will be discussed during the facility's quarterly	
			QA meetings and the plan adjusted accordingly, if warranted.	

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