

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155253	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2016
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NAME OF PROVIDER OR SUPPLIER MEADOWOOD HEALTH PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 2455 TAMARACK TR BLOOMINGTON, IN 47408
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 21, 22, 23, 24, 25, and 26, 2016.</p> <p>Facility number: 000156 Provider number: 155253 AIM number: N/A</p> <p>Census bed type: SNF: 35 Total: 35</p> <p>Census payor type: Medicare: 7 Other: 28 Total: 35</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on September 01, 2016.</p>	F 0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 25th, 2016 to the annual licensure survey conducted on August 26th, 2016.</p> <p>We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <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, interview, and record review, the facility failed to ensure staff treated residents in a dignified manner for 1 of 30 residents reviewed. (Resident #85)</p> <p>Findings include:</p> <p>During an interview, on 8/23/16 at 3:27 p.m., Resident #85 indicated he hates the alarm the staff put on his wheelchair because every time he bends over it goes off. He further indicated he has never been treated so much like a child in his life. He then demonstrated how easily the alarm goes off by leaning over in his wheelchair, thereby sounding off the alarm.</p> <p>Observations of Resident #83 included the following:</p> <p>On 8/24/16 at 9:56 a.m., the resident was</p>	F 0241	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 25th, 2016 to the annual licensure survey conducted on August 26th, 2016. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.</p> <p>F241</p> <p>It is the practice of this facility to assure that care is promoted 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>The correction action taken for</p>	09/25/2016

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	<p>observed in his bedroom sitting in the wheelchair with the chair alarm in place.</p> <p>On 8/24/16 at 3:44 p.m., the resident was observed sitting in the wheelchair with the chair alarm in place.</p> <p>On 8/25/16 at 9:41 a.m., the resident was observed reading in wheelchair with the alarm in place.</p> <p>On 8/25/16 at 1:55 p.m., the resident was observed participating in therapy with the chair alarm in place.</p> <p>On 8/26/16 at 10:37 a.m., Resident #85's clinical record was reviewed. Diagnosis included, but was not limited to: history of falls.</p> <p>A review of Resident #85's MDS (Minimum Data Set) dated, 8/14/16, indicated a BIMS (Brief Interview for Mental Status) total score of 13, with a total score of 13 to 15 being cognitively intact.</p> <p>Resident #85's care plan titled, "Resident at risk for falling R/T [related to] hx [history] of falls, weakness, and impaired balance," had start date of 8/16/16 and a target goal date of 11/16/16. Approaches included, but were not limited to, "... pressure pad alarm at all times ..." with a</p>		<p>those residents found to be affected by the deficient practice include:</p> <p>Alarms were immediately removed from resident #85 and careplan has been updated to reflect current status, as well as c.n.a. assignmentsheet.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Residents who had alarms had the potential to be affected and residents with any type alarm have been interviewed. No additional residents were identified.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>An in-service has been conducted with employees regarding Dignity related to Staff sharing any resident being upset about the placement of a safety device.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly observes 5 residents with alarms/safety devices observing resident wishes for usage. The Social Services Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at</p>	

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	<p>start date of 8/16/16.</p> <p>During an interview, on 8/25/16 at 10:15 a.m., LPN #1 indicated Resident #85 was admitted after he fell in his home and he has the alarm for safety awareness. She further indicated the alarm does not seem to bother him very much, however, every once in awhile he'll mention something about the alarm going off if he stands up too much.</p> <p>On 08/26/16 9:32 a.m., Resident #85 indicated the DON (Director of Nursing) came in his room and said she was taking the alarm off of me. He further indicated having the alarm off makes him me feel pretty good and now he can go anywhere without the alarm going off.</p> <p>On 8/26/16 at 2:02 p.m., LPN #3 indicated Resident #85 was very happy to have the alarm off.</p> <p>On 8/26/16 at 2:15 p.m., the DON provided the facility policy, "Resident Rights," dated 12/08/08, and indicated it was the policy currently being used. The policy indicated, ".... Basic Rights. You have the right to be treated with respect and dignity in recognition of your individuality and preferences..."</p> <p>3.1-3(t)</p>		<p>the scheduled meetings with recommendations for new interventions or training as needed based on the outcome of the PI tool.</p> <p>The date the systemic changes will be completed: September 25th, 2016</p>		

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F 0441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <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</p>			
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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing as indicated by facility policy for 1 of 3 observations for infection control. (Resident #14)</p> <p>Findings include:</p> <p>On 8/26/2016 at 10:31 a.m., Certified Nursing Assistant #1 (CNA) and CNA #2 were observed to remove an incontinent brief that was dirty with urine and to perform perineal care on Resident #14. CNA #1 and CNA #2 were then observed to put a new incontinent brief on the resident, straighten her shirt and pull the blanket to cover Resident #14 up. No glove change or handwashing was observed during this time.</p> <p>During an interview with CNA #1 and CNA #2 on 8/26/2016 at 10:40 a.m., both CNA's did not deny that they should have changed gloves and wash their hands before applying the new incontinent brief and touching Resident #14's clothes and bed linen.</p> <p>On 8/26/2016 at 2:15 p.m., the Director of Nursing (DON) provided the policy, "Hand Washing" with a revision date of</p>	F 0441	<p>F441</p> <p>It is the practice of this facility to assure that infection control practices are followed related to hand washing to prevent the development and transmission of disease and infection.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>C.n.a #1 and #2 were given Teachable Moments regarding Handwashing/changing gloves during resident care.</p> <p>Review of the CDC most current handwashing criteria conducted with staff immediately on 08/26/16.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Residents who receive incontinent care had the potential to be affected, but none were identified.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>Staff has been in-serviced on Handwashing Policy with a focus on proper procedure during resident personal care.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly</p>	09/25/2016

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F 0465 SS=D Bldg. 00	<p>2/17/2016, and indicated the policy was the one currently being used by the facility. The policy indicated, " ... 5.0 PROCEDURE 1. e. After contact with soiled or contaminated articles, such as articles that are contaminated with blood or body fluids. ..."</p> <p>On 8/26/2016 at 3:00 p.m., review of Center for Disease Control at www.cdc.gov/handhygiene/providers/index.html, with a last reviewed date of 4/28/2016, indicated, "When to perform hand hygiene ... After contact with ... body fluids or excretions. ..."</p> <p>3.1-18(I)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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 privacy curtains and wall next to the resident's bed were free from stains and disrepair in 1 of 30 resident rooms (Resident 18).</p> <p>Findings include:</p>	F 0465	<p>observes 3 staff members during resident care for proper handwashing/glove removal. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3 and conduct random audits to include all shifts 7 days a week. Any issues with staff observed out of compliance, re-education will be initiated. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.</p> <p>The date the systemic changes will be completed: September 25th, 2016</p> <p>F465 It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The correction action taken for those residents found to be affected by the deficient practice include: 1. Cubicle Curtains for Resident</p>	09/25/2016

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	<p>On 8/22/16 at 2:28 P.M., during an inspection of the room for Resident 18, the two privacy curtains around the resident's bed were observed to be stained with a dark brown substance. The wall to the left of the resident's bed was also observed to be stained with a dark brown substance. The stained wall was damaged with several holes in the drywall.</p> <p>On 8/24/16 at 2:45 P.M., during an interview, Resident 18 indicated she stayed in her room most of the time and considered it her temporary residence.</p> <p>On 8/25/16 at 10:40 A.M., the privacy curtains and wall in the room of Resident 18 were observed to be in the same stained and damaged condition as when originally observed.</p> <p>On 8/25/16 at 11:00 A.M., during an interview, the Director of Housekeeping and Maintenance indicated the resident rooms received daily inspection and cleaning which included inspection of privacy curtains and walls. The rooms also received a deep cleaning every 30 days. He indicated the rooms should not have stains on the walls or privacy curtains, nor should there be holes in the walls.</p>		<p>#18 were immediately replaced. 2. The Wall to the left of Resident #18 was immediately Cleaned and Repaired. Other residents that have the potential to be affected have been identified by: Residents had the potential to be effected. Full House review of all curtains and walls conducted. No other residents were noted to be affected. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Housekeeping staff has been in-serviced related to during daily cleaning rounds to monitor curtains for stains and walls for stains/holes and correcting/cleaning immediately. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 Resident Rooms for stained curtains and Stains/Holes in walls. The Housekeeping/Laundry Director, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of</p>				

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	On 8/26/16 at 2:00 P.M., the Social Services Director provided a written copy of the facility's Resident's Rights which stated the resident has a right to, "....a safe, clean, comfortable, home-like environment...". 3.1-19(f)		the PI tool. <i>The date the systemic changes will becompleted:</i> September 25th, 2016		