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| 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 07/17/2013 |
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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 the Investigation of Complaints IN00132362 and IN00132363.</p> <p>Complaint IN00132362 - Substantiated. Federal/State deficiencies related to the allegations are cited at F240, F241, F244, F309, F353, F364 and F456.</p> <p>Complaint IN00132363 - Substantiated. Federal/State deficiencies related to the allegations are cited at F240, F241, and F456.</p> <p>Survey dates: July 15, 16, and 17, 2013</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Surveyor: Betty Retherford RN, TC</p> <p>Census bed type: SNF/NF: 56 SNF: 4 Total: 60</p> <p>Census payor type: Medicare: 7 Medicaid: 47</p> | F000000 | . | |

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: 6 Total: 60</p> <p>Sample: 8</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> | | | |

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| F000240 SS=E | <p>483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents who required the use of a hoyer lift in order to be transferred from their bed into a wheelchair had their needs met in order to enhance their quality of life for 3 of 3 residents reviewed for Hoyer lift transfers in a sample of 8. (Resident #'s C, B, and F) This had the potential to affect 6 of 6 residents residing in the building requiring the need for a Hoyer lift for transfers.</p> <p>Findings include:</p> <p>During an observation with CNA #2 on 7/15/13 at 6:30 a.m., there were 2 electric Hoyer lifts and one mechanical Hoyer lift in the building. Both electric Hoyer lifts were charged and in working order. CNA #2 indicated the charger for the Hoyer lifts had not been in working order the previous week and the Hoyer lifts could not be used for several days. She indicated the mechanical lift was rarely used.</p> <p>1.) The clinical record for Resident #F</p> | F000240 | <p>1. Resident B, C and F incurred no negative outcome. The Hoyer lift and the chargers are now functioning properly. 2. All residents who utilize the Hoyer lift for transfers have the potential to be affected. The Hoyer lift and the chargers are now functioning properly. 3. The facility has purchased extra chargers. In the future, should the hoyer lift or the charger malfunction the staff is to alert the DON immediately who will then assess the needs of those residents who require Hoyer transfers and an alternate transfer process will be initiated, as warranted. All staff has been re-educated on what to do in the future should there be mechanical failure of the hoyer lift or its chargers. 4. The DON or her designee will monitor to ensure the Hoyer lift and the chargers are functioning properly daily on scheduled days of work daily for 2 weeks, three times a week for 2 weeks and then weekly until compliance is maintained for 6 consecutive months. (See Attachment 1)Should concerns be observed, re-education shall be provided. The results of said observations will be reviewed</p> | 08/02/2013 | | | |

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| | <p>was reviewed on 7/16/13 at 8:30 a.m.</p> <p>Diagnoses for Resident #F included, but were not limited to, diabetes mellitus, neuropathy, obesity, chronic pain, muscle spasms, and osteoarthritis.</p> <p>A quarterly minimum data set assessment, dated 6/15/13, indicated the resident was not cognitively impaired. She was identified as "interviewable" on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>Current physician's orders for Resident #F indicated she was to be up with assistance as tolerated.</p> <p>A fall risk health care plan problem, dated 6/13/13, indicated the resident was to use a wheelchair for mobility and a Hoyer lift was to be used for safe resident transfers.</p> <p>During an interview on 7/15/13 at 1:45 p.m., Resident #F was up in her chair in her room. She indicated she had been unable to get out of bed on "Monday, Tuesday, and Wednesday" of the last week (July 8, 9, and 10, 2013) because the Hoyer lift was not working. She indicated the Hoyer lift was in working order by Wednesday afternoon, but it was not working until the time that she usually would have gone back to bed, so she did</p> | | <p>during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.</p> | | | | |

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| | <p>not get up. She indicated she is usually out of bed for 5 to 7 hours a day. She indicated the mechanical lift was not used because it had a "weight limit" and was not secure.</p> <p>2.) The clinical record for Resident #C was reviewed on 7/15/13 at 10:05 a.m.</p> <p>Diagnoses for Resident #C included, but were not limited to, chronic pain, muscle spasms, gastric esophageal reflux disease, and cerebrovascular accident.</p> <p>A quarterly minimum data set assessment, dated 6/15/13, indicated the resident was not cognitively impaired. She was identified as "interviewable" on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>Current physician's orders for Resident #C indicated she was to be up with assistance in her wheelchair.</p> <p>A health care plan problem, dated 3/26/13, indicated the resident required the assistance of the staff for activities of daily living. The resident's name was on a list provided by the Administrator on 7/15/13 at 8:25 a.m., which indicated she required the use of a Hoyer lift for transfers.</p> | | | |

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| | <p>During an interview on 7/15/13 at 2 p.m., Resident #C was up in her wheelchair in her room watching television. She indicated she had been unable to get out of bed at least 3 days the previous week because there was no Hoyer lift in working order available. She indicated she preferred to be up in her wheelchair during the day and did not like staying in bed.</p> <p>3.) The clinical record for Resident #B was reviewed on 7/15/13 at 8:40 a.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, post motor vehicle accident with spinal cord injury and paraplegia, depression, chronic pain syndrome, and degenerative joint disease.</p> <p>A quarterly minimum data set assessment, dated 6/6/13, indicated the resident was not cognitively impaired. She was identified as "interviewable" on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>A fall risk health care plan problem, dated 6/11/13, indicated a Hoyer lift was to be used for transfers. The resident's name was on a list provided by the Administrator on 7/15/13 at 8:25 a.m., which indicated she required the use of a Hoyer lift for transfers.</p> | | | |

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| | <p>During an interview on 7/15/13 at 2:20 p.m., Resident #B was up in her wheelchair in her room watching television. She indicated there had been a problem the previous week with the Hoyer lift not working and she had been unable to get out of bed as she desired to go smoke. She indicated she had become upset by this and insisted the staff transfer her manually from her bed to her wheelchair. She indicated multiple staff came to her room and complied with her wishes, but informed her she would need to go back to bed later that day while there was enough staff present to put her to bed. She indicated she told them she wanted to stay up in her wheelchair (which would recline back) all night. She indicated the staff were able to perform her "in and out" catheterizations while she was reclined back in her special wheelchair. She indicated the facility was not happy with her decision to stay in the chair all night, but indicated they would honor her wishes. Resident #B indicated she became tired during the night and then asked to be put back to bed. She indicated the midnight staff that night refused to put her back to bed because they didn't feel there was enough staff present for a safe manual transfer. She indicated she then stayed up in her wheelchair and was not put back to bed</p> | | | |

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| | <p>until the following day.</p> <p>4.) During an interview with the Administrator and Director of Nursing (DoN) on 7/15/13 at 2:55 p.m., additional information was requested related to the Hoyer lifts not being operable the previous week and Resident #B not being put back to bed as she requested.</p> <p>During an interview on 7/15/13 at 2:55 p.m., the DoN indicated there had been a problem with the Hoyer lifts not being in working order the previous week. She indicated the facility had previously had only one charger for both electric Hoyer lifts in the facility. She indicated the charger stopped working on 7/7/13 (a Sunday), but both hoers had a partial charge that could be used for some residents until it became depleted on Monday 7/8/13. She indicated new chargers for the lifts had been ordered on 7/8/13 and arrived at the facility sometime on Wednesday July 10, 2013.</p> <p>Both the DoN and Administrator indicated they had talked to the Resident #B regarding her wanting to be manually transferred into the chair the previous week and her decision to not go to bed when staff was available. The Administrator indicated she had told the nursing staff on the midnight shift to call</p> | | | | | | |

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| | <p>if the resident changed her mind and wanted to go back to bed and she would obtain staff to complete the transfer. The Administrator indicated staff had not contacted her regarding the resident's request to be put back to bed and she was unaware of this information until this interview.</p> <p>This federal tag relates to Complaint numbers IN00132362 and IN00132363.</p> <p>3.1-32(a)</p> | | | |

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| F000241 SS=E | <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 record review and interview, the facility failed to ensure services were provided in a manner to promote resident dignity and quality of life for 3 of 5 residents (Resident #F, J, and G) reviewed for timely call light response and for 1 of 1 resident (Resident #B) reviewed who's desire to be transferred back into bed was not honored in a sample of 8.</p> <p>Findings include:</p> <p>1.) During interviews on the following dates and times, resident concerns were identified in regards to residents having to wait a long time for their call light to be answered. Each resident interviewed below was identified as alert, oriented, and interviewable on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>During an interview on 7/15/13 at 1:45 p.m., Resident #F indicated she had to wait over 15 minutes for her call light to be answered at least 3 times a week. She indicated the problem was worse on the</p> | F000241 | <p>1. Resident F, J, and G incurred no negative outcomes. Call lights are being answered promptly and resident needs addressed, as warranted. Additionally, the facility has corrected concerns with function/charge of the hoyer lift, thus honoring resident B's desire to return to bed upon request should remedied. 2. All residents have the potential to be affected. The call lights will be answered promptly and resident needs will be addressed, as warranted, including timely transfer back to bed upon request. 3. The Policy and Procedure for responding to call lights has been reviewed with no revisions made. (See Attachment 2)The staff has been re-educated on the policy and procedure. The facility has implemented a policy in response to concerns with function/charge of lifts as described in the plan of correction for F240. 4. The DON or her designee will conduct 3 resident interviews on random halls to ensure call lights are answered in an appropriate time frame and that the resident requests/needs were addressed appropriately on scheduled days of work daily for 2 weeks, two</p> | 08/02/2013 | | | |

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| | <p>2nd shift, especially when the staff were taking their supper break. She indicated the problems were worse when there were "call-ins" and the staff were "working short."</p> <p>During an interview on 7/16/13 at 9 a.m., Resident #J indicated she waits over 15 minutes for her call light to be answered at least 4-5 times a week. She indicated the aides were always being moved from unit to unit and she didn't think there was enough staff to answer the call lights timely.</p> <p>During an interview on 7/17/13 at 10:55 a.m., Resident #G indicated there had been a problem with call lights in the facility that might be slightly better, but she still waited over 15 minutes for her call lights to be answered at least 2 times a week. She indicated she didn't feel like there was enough staff and the CNAs always smelled like "smoke" when they came to answer a call light that had been on a long time.</p> <p>Review of a current facility policy, dated 9/05, provided by the Administrator on 7/16/13 at 11:30 a.m., titled "Call Light Procedure", included, but was not limited to, the following:</p> <p>"Purpose: To allow resident to request</p> | | <p>times a week for two weeks then weekly until compliance is maintained for 6 consecutive months. (See Attachment 3) Should concerns be observed, re-education will be provided. The results of said observation and any corrective actions taken will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted. The DON or her designee will monitor to ensure the Hoyer lift and the chargers are functioning properly daily on scheduled days of work daily for 2 weeks, three times a week for 2 weeks and then weekly until compliance is maintained for 6 consecutive months. (See Attachment 1)Should concerns be observed, re-education shall be provided. The results of said observations will be reviewed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.</p> | | |

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| | <p>assistance when needed.</p> <p>...Procedure:</p> <ol style="list-style-type: none"> 1. Place call light within reach of resident at all times. 2. Answer light promptly. All staff should respond to a call light promptly (Bathroom/shower room call light immediately)...." <p>2.) The clinical record for Resident #B was reviewed on 7/15/13 at 8:40 a.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, post motor vehicle accident with spinal cord injury and paraplegia, depression, chronic pain syndrome, and degenerative joint disease.</p> <p>A quarterly minimum data set assessment, dated 6/6/13, indicated the resident was not cognitively impaired. She was identified as "interviewable" on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>A fall risk health care plan problem, dated 6/11/13, indicated a Hoyer lift was to be used for transfers. The resident's name was on a list provided by the Administrator on 7/15/13 at 8:25 a.m., which indicated she required the use of a</p> | | | |

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| | <p>Hoyer lift for transfers.</p> <p>During an interview on 7/15/13 at 2:20 p.m., Resident #B was up in her wheelchair in her room watching television. She indicated there had been a problem the previous week with the Hoyer lift not working and she had been unable to get out of bed as she desired to go smoke. She indicated she had become upset by this and insisted the staff transfer her manually from her bed to her wheelchair. She indicated multiple staff came to her room and complied with her wishes, but informed her she would need to go back to bed later that day while there was enough staff present to put her to bed. She indicated she told them she wanted to stay up in her wheelchair (which would recline back) all night. She indicated the staff were able to perform her "in and out" catheterizations while she was reclined back in her special wheelchair. She indicated the facility was not happy with her decision to stay in the chair all night, but indicated they would honor her wishes. Resident #B indicated she became tired during the night and then asked to be put back to bed. She indicated the midnight staff that night refused to put her back to bed because they didn't feel there was enough staff present for a safe manual transfer. She indicated she then stayed up in her</p> | | | | | | |

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| | <p>wheelchair and was not put back to bed until the following day.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 7/15/13 at 2:55 p.m., additional information was requested related to the Hoyer lifts not being operable the previous week and Resident #B not being put back to bed as she requested.</p> <p>During an interview on 7/15/13 at 2:55 p.m., the DoN indicated their had been a problem with the Hoyer lifts not being in working order the previous week. She indicated the facility had previously had only one charger for both electric Hoyer lifts in the facility. She indicated the charger stopped working on 7/7/13 (a Sunday), but both Hoyers had a partial charge that could be used for some residents until it became depleted on Monday 7/8/13. She indicated new chargers for the lifts had been ordered on 7/8/13 and arrived at the facility sometime on Wednesday July 10, 2013.</p> <p>Both the DoN and Administrator indicated they had talked to the Resident #B regarding her wanting to be manually transferred into the chair the previous week and her decision to not go to bed when staff was available. The Administrator indicated she had told the</p> | | | | | | |

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| | <p>nursing staff on the midnight shift to call if the resident changed her mind and wanted to go back to bed and she would obtain staff to complete the transfer. The Administrator indicated staff had not contacted her regarding the resident's request to be put back to bed and she was unaware of this information until this interview.</p> <p>This federal tag relates to Complaint numbers IN00132362 and IN00132363.</p> <p>3.1-3(t)</p> | | | |

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| F000244 SS=E | <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on record review and interview, the facility failed to ensure grievances expressed during resident council meetings related to the lack of timely call light response were acted upon in a manner to prevent recurrence for 3 of 5 residents reviewed for timely call light response in a sample of 8. (Resident #F, J, and G)</p> <p>Findings include:</p> <p>Review of the March and May 2013 resident council minutes, provided by the Administrator on 7/15/13 at 11:00 a.m., included, but were not limited to, the following:</p> <p>March 14, 2013 at 2:30 p.m.: "Residents have issues with call light not being answered in a timely manner." Sixteen residents in attendance.</p> <p>May 5, 2013 at 2:30 p.m.: "2 nd shift call lights still not being answered on time. 'All units.' 2nd shift sits behind desk laughing, goofing off, refusing to answer</p> | F000244 | <p>1. Resident F, J, and G incurred no negative outcome. Call lights are answered promptly and resident needs addressed, as warranted. 2. All residents have the potential to be affected. Call lights are answered promptly and resident needs addressed, as warranted. Grievances voiced through resident council during the past 12 months have again been reviewed and to confirm that said grievances have been addressed. 3. The policy and procedure for Grievances has been reviewed and no revisions were made. Administrative staff has been re-educated on the policy. 4. The Administrator or her designee will monitor grievances to ensure concerns voiced are investigate, addressed in a timely and appropriate manner, as well as ensuring corrective action has been initiated and follow up monitoring assigned to assess compliance daily on scheduled days of work. (See Attachment 5)Should concerns be noted, re-education will be provided. The grievance process, including review of grievances and</p> | 08/02/2013 | | | |

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| | <p>call lights and taking care of residents."</p> <p>During interviews on the following dates and times, resident concerns were identified in regards to residents having to wait a long time for their call light to be answered. Each resident interviewed below was identified as alert, oriented, and interviewable on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>During an interview on 7/15/13 at 1:45 p.m., Resident #F indicated she had to wait over 15 minutes for her call light to be answered at least 3 times a week. She indicated the problem was worse on the 2nd shift, especially when the staff were taking their supper break. She indicated the problems were worse when there were "call-ins" and the staff were "working short."</p> <p>During an interview on 7/16/13 at 9 a.m., Resident #J indicated she waits over 15 minutes for her call light to be answered at least 4-5 times a week. She indicated the aides were always being moved from unit to unit and she didn't think there was enough staff to answer the call lights timely.</p> <p>During an interview on 7/17/13 at 10:55 a.m., Resident #G indicated there had been a problem with call lights in the</p> | | corrective actions taken, will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted. | | |

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| | <p>facility that might be slightly better, but she still waited over 15 minutes for her call lights to be answered at least 2 times a week. She indicated she didn't feel like there was enough staff and the CNAs always smelled like "smoke" when they came to answer a call light that had been on a long time.</p> <p>Review of a current facility policy, dated 9/05, provided by the Administrator on 7/16/13 at 11:30 a.m., titled "Call Light Procedure", included, but was not limited to, the following:</p> <p>"Purpose: To allow resident to request assistance when needed.</p> <p>...Procedure:</p> <ol style="list-style-type: none"> 1. Place call light within reach of resident at all times. 2. Answer light promptly. All staff should respond to a call light promptly (Bathroom/shower room call light immediately)...." <p>This federal tag relates to Complaint number IN00132362.</p> <p>3.1-3(I)</p> | | | | | | |

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| F000309 SS=D | <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received treatment services as ordered by the physician for 1 of 3 residents reviewed for wound treatments in a sample of 8. (Resident #B)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 7/15/13 at 8:40 a.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, post motor vehicle accident with spinal cord injury and paraplegia, depression, chronic pain syndrome, and degenerative joint disease.</p> <p>A quarterly minimum data set assessment, dated 6/6/13, indicated the resident was not cognitively impaired. She was identified as "interviewable" on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>A temporary problem list, dated 7/5/13,</p> | F000309 | <p>1. Resident B incurred no negative outcome. The clinical record for this resident has been reviewed to identify staff responsible to perform treatments on dates in question. Said staff will be addressed, as applicable.</p> <p>2. All residents who have orders for treatments have the potential to be affected. The clinical records for all residents in the facility have been reviewed to confirm that treatments have been completed as ordered. Should concerns be noted, applicable staff shall be addressed, as well as residents assessed for any potential negative outcome and corrective action taken as warranted.</p> <p>3. The facility policy and procedure for medication/treatment administration has been reviewed and no revisions were made. (See Attachment 6a and 6b) The staff has been re-educated on the policy and procedure.</p> <p>4. The DON or her designee will observe 5 residents to ensure treatments are completed as ordered on scheduled days of work daily for two weeks, three times a week</p> | 08/02/2013 | | | |

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| | <p>indicated Resident #B and an area on her left heel and one of the approaches was for the physician ordered treatment to be done every day as ordered.</p> <p>A "Skin Condition Report for Non-Pressure Related Skin Conditions", dated 7/12/13, indicated the area was related to "shearing from shoe". The area measured 7 centimeters (cm) by 7 cm with less than 0.1 cm of depth. The area was described as "red" with peeling skin around it.</p> <p>A physician's order, dated 7/5/13, indicated the staff were to cleanse the area on the left heel with Betadine solution, apply xeroform, cover with dressing and wrap with kerlex daily.</p> <p>During an interview on 7/15/13 at 2 p.m., Resident #B indicated she had an area on her left heel and the nursing staff were not always completing the treatment daily as ordered by the physician. She indicated the treatment had not yet been completed on 7/15/13 and was supposed to be done on the day shift (6 a.m. to 2 p.m.).</p> <p>During an interview on 7/16/13 at 10:20 a.m., Resident #B indicated her heel treatment had already been completed that morning. When asked if the treatment was ever provided yesterday (7/15/13),</p> | | <p>for two weeks and then weekly until compliance is maintained for 6 consecutive months. (See Attachment 7)Should concerns be observed, re-education will be provided. The results of said observations and any corrective actions taken will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.</p> | |

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| | <p>she indicated "No, it was not done."</p> <p>The July 2013 Medication Administration Record (MAR) had the resident's heel treatment order written in and space made for documentation of the treatment. The treatment had been ordered on 7/5/13 to be started on 7/6/13. The MAR indicated the treatment was not started until 7/8/13. The MAR lacked any indication the treatment had been completed on July 11, 12, and 15, 2013 as ordered by the physician.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 7/16/13 at 12:10 p.m., additional information was requested related to the wound treatments not being completed as ordered for Resident #B.</p> <p>The facility failed to provide any additional information as of exit on 7/17/13.</p> <p>This federal tag relates to Complaint number IN00132362.</p> <p>3.1-37(a)</p> | | | | |

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| F000353 SS=E | <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review, and interview, the facility failed to ensure there were sufficient staff available to answer call lights timely, deliver food trays timely, and transfer a resident back to bed as she desired for 6 of 8 residents reviewed for sufficient staff in a sample of 8. (Resident #'s C, E, B, F, J, and G)</p> <p>Findings:</p> <p>During an interview on 7/15/13 at 6:20 a.m., LPN #5 indicated three CNAs scheduled to be at work at 6 a.m., had not</p> | F000353 | <p>1. Residents C, E, B, F, J, and G incurred no negative outcome.</p> <p>2. All residents have the potential to be affected. Thus, the following corrective actions have been taken. 3. The facility has reviewed the nursing schedule and sufficient staff is scheduled. Should the facility receive call-off(s) that could potentially result in decreased staffing levels, the scheduling coordinator will be alerted. The required amount of staff to replace the call-offs will be mandated to remain on duty until replacement arrangements can be made. Should the current staff</p> | 08/02/2013 | | | |

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| | <p>arrived yet and a fourth CNA had "called in." LPN #5 indicated one of the CNAs was on her way to the building, but the facility had not heard from the other two who had not yet arrived. She indicated they were in the process of obtaining additional staff.</p> <p>During an observation on 7/15/13 at 7:12 a.m., a food cart was rolled from the kitchen to the back dining room and placed in the dining room. At 7:22 a.m. CNA #4 began to pass the trays from the cart to the residents in the dining room. After the dining room was served, the CNA began to take trays from the cart and deliver them to individual resident's rooms. At 7:42 a.m., CNA #4 delivered a tray to Resident #C. This indicated a time period of 30 minutes from the time the cart was delivered to the unit and Resident #C received her breakfast tray. A tray was delivered to Resident #B's room at 7:44 a.m. This indicated a time period of 32 minutes from the time the food cart was delivered to the unit and Resident #B received her tray.</p> <p>During interviews on the following dates and times, resident concerns were identified in regards to timely staff services and sufficient staff. Each resident interviewed below was identified as alert, oriented, and interviewable on a</p> | | <p>on duty refuse to remain, re-education/disciplinary actions will be provided/taken. In the event that floor staff is not available to fill a vacancy, nursing administration will be required to fill the vacancy until other arrangements can be made. Nursing staff has been re-educated on the above action plan. Call light response and available staff for resident requested transfer have been addressed in plans of correction submitted for respective deficiencies. In regard to timely tray delivery, administrative staff shall conduct tray delivery observations of varied meals on varied shifts daily on scheduled days of work for two weeks, three times a week for two weeks then weekly until compliance is maintained for 6 consecutive months. (See attachment 8). 4. The Administrator or her designee will review staffing to ensure the appropriate amount of staff is scheduled and that call-offs are replaced Should concerns be observed, re-education will be provided. (See attachment 9)The results of said observations will be discussed during the facilities quarterly QA meetings and the plan adjusted accordingly, if warranted. As grievances can be reflective of concerns with sufficient staffing, The Administrator or her designee will monitor grievances to ensure</p> | | | | |

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| | <p>list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>During an interview on 7/15/13 at 7:40 a.m., Resident #C indicated her sausage and hot cereal items were both cold. CNA #4 returned to the resident's room at this time and offered to heat the food items up for the resident. The CNA indicated she was the only aide working in the back dining room area on this date and that most of the time there were two aides back there.</p> <p>During an interview on 7/15/13 at 7:50 a.m., Resident #E (also a room tray resident on the back hall) indicated the sausage was cold. He indicated the food was "always cold."</p> <p>During an interview on 7/15/13 at 2:20 p.m., Resident #B (a room tray resident on the back hall) indicated the food was cold at least 2-3 times a week. Resident #B also indicated she had to be manually transferred to her wheelchair last week when the electronic Hoyer lifts were not in working order. She indicated she had requested to be manually transferred back to bed during the night during the previous week and the staff were unable to provide this service due to insufficient staff. She indicated she stayed up in her electric wheelchair all night due to not</p> | | <p>concerns voiced are investigate, addressed in a timely and appropriate manner, as well as ensuring corrective action has been initiated and follow up monitoring assigned to assess compliance daily on scheduled days of work. Should concerns be noted, re-education will be provided. The grievance process, including review of grievances and corrective actions taken, will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.</p> | | | | |

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| | <p>enough staff to manually put her back to bed.</p> <p>During an interview on 7/15/13 at 2:55 p.m., the DoN indicated there had been a problem with the Hoyer lifts not being in working order the previous week. Both the DoN and Administrator indicated they had talked to Resident #B regarding her wanting to be manually transferred into the chair the previous week and her decision to not go to bed when staff was available to transfer her. The Administrator indicated she was unaware of Resident #B's later request during the night to go back to bed which had not been honored.</p> <p>During an interview on 7/15/13 at 1:45 p.m., Resident #F indicated she had to wait over 15 minutes for her call light to be answered at least 3 times a week. She indicated the problem was worse on the 2nd shift, especially when the staff were taking their supper break. She indicated the problems were worse when there were "call-ins" and the staff were "working short."</p> <p>During an interview on 7/16/13 at 9 a.m., Resident #J indicated she waits over 15 minutes for her call light to be answered at least 4-5 times a week. She indicated the aides were always being moved from</p> | | | | | | |

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| | <p>unit to unit and she didn't think there was enough staff to answer the call lights timely.</p> <p>During an interview on 7/17/13 at 10:55 a.m., Resident #G indicated there had been a problem with call lights in the facility that might be slightly better, but she still waited over 15 minutes for her call lights to be answered at least 2 times a week. She indicated she didn't feel like there was enough staff and the CNAs always smelled like "smoke" when they came to answer a call light that had been on a long time.</p> <p>This federal tag relates to Complaint number IN00132362.</p> <p>3.1-17(a)</p> | | | |

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| 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 07/17/2013 | |
| 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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| F000364 SS=E | <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to ensure food was served that was palatable and at the proper temperature for 7 of 7 residents reviewed for food palatability in a sample of 8. (Resident #'s F, H, E, C, B, G, and J) This had the potential to affect 57 of 60 residents who ate meals prepared by the facility staff.</p> <p>Findings Include:</p> <p>During an interview on 7/15/13 at 6:20 a.m., LPN #5 indicated three CNAs scheduled to be at work at 6 a.m., had not arrived yet and a fourth CNA had "called in." LPN #5 indicated one of the CNAs was on her way to the building, but the facility had not heard from the other two who had not yet arrived.</p> <p>During an observation on 7/15/13 at 7:12 a.m., a food cart was rolled from the kitchen to the back dining room and placed in the dining room. At 7:22 a.m. CNA #4 began to pass the trays from the cart to the residents in the dining room.</p> | F000364 | <p>1. Resident's #F, H, E, C, B, and J incurred no negative outcomes. The meal tray delivery has been timely and temperature of food has been served at a palatable temperature. 2. All residents have the potential to be affected. The meal tray delivery has been timely and temperature of food has been palatable temperature. 3. The facility has developed the following action plan to ensure proper food temperatures. Heated plates with insulated dome lids will be used to serve the main dish food and meal trays will be transported in a closed cart to the units to maintain foods temperatures at a palatable level when arriving on the units. The dietary department will monitor food temperatures at each meal to ensure food is at a proper temperature. (See Attachment 10a, 10b and 10c) Dietary staff has been re-educated on this procedure. The DON or her designee will conduct meal tray delivery observations of varied meals on varied shifts daily on scheduled days of work for two weeks, three times a week for two weeks then weekly thereafter until compliance is maintained for</p> | 08/02/2013 | | | |

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| | <p>After the dining room was served, the CNA began to take trays from the cart and deliver them to individual resident's rooms. At 7:42 a.m., CNA #4 delivered a tray to Resident #C. This indicated a time period of 30 minutes from the time the cart was delivered to the unit and Resident #C received her breakfast tray. A tray was delivered to Resident #B's room at 7:44 a.m. This indicated a time period of 32 minutes from the time the food cart was delivered to the unit and Resident #B received her tray.</p> <p>During interviews on the following dates and times, resident concerns were identified in regards to palatable food served at the proper temperature. Each resident interviewed below was identified as alert, oriented, and interviewable on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>During an interview on 7/15/13 at 7:40 a.m., Resident #C indicated her sausage and hot cereal items were both cold. CNA #4 returned to the resident's room at this time and offered to heat the food items up for the resident. The CNA indicated she was the only aide working in the back dining room area on this date and that most of the time there were two aides back there.</p> | | <p>6 consecutive months. 4. The Dietary Manager or her designee will conduct observations of one meal of varied meals on scheduled days of work to ensure food is served at a palatable temperature. Said observations shall include observations of each meal at least one time. (See Attachment 11) Should concerns be observed, re-education will be provided. The results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted. The DON or her designee will conduct meal tray delivery observations of varied meals of varied shifts on scheduled days of work to ensure meal trays are delivered timely daily for two weeks, three times a week for two weeks then weekly until compliance is maintained for 6 consecutive months. (See Attachment 8) Should concerns be observed, re-education shall be provided. The results of said observations will be reviewed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.</p> | | | | |

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| | <p>During an interview on 7/15/13 at 7:50 a.m., Resident #E (also a room tray resident on the back hall) indicated the sausage was cold. He indicated the food was "always cold."</p> <p>During an interview on 7/15/13 at 7:35 a.m., Resident #H (eating in the main dining room) indicated both her sausage patties and omelet were cold when served.</p> <p>During an interview on 7/15/13 at 1:45 p.m., Resident #F indicated she eats in her room and the food was cold "most of the time." She indicated oatmeal was now being served in a very small dessert bowl instead of a cereal bowl, which did not allow any room to put milk in with it and fix it the way she liked.</p> <p>During an interview on 7/15/13 at 2:20 p.m., Resident #B indicated the food was cold at least 2-3 times a week. She indicated there was not much variety and it was not appetizing.</p> <p>During an interview on 7/16/13 at 9 a.m., Resident #J indicated she had lived at the facility for several years and the food was "worse than it has ever been." She indicated the food was cold at least once a day. She indicated she continually received foods that were noted on her "dislikes" list.</p> | | | | | | |

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| | <p>During an interview on 7/17/13 at 10:55 a.m., Resident #G indicated she frequently gets milk and other items from her "dislikes" list served on her tray. She indicated the buns are dry, the sloppy joes are watery, the peas are hard, the bologna seems to be a very "cheap" variety. She indicated she receives cold food at least once a day.</p> <p>During an interview with Cook #1 on 7/15/13 at 12:30 p.m., additional information was requested related to the monitoring of food temps prior to them being served. Cook #1 obtained the temperature monitoring records for July 2013 and multiple blanks were noted where the temperatures of the foods should have been recorded.</p> <p>During an interview with the Dietary Manager on 7/15/13 at 12:25 p.m., food temperature monitoring logs for June 2013 were also requested. The Dietary Manager indicated she had just started on July 1, 2013, but reviewed both the June and July 2013 logs.</p> <p>The food temperature monitoring records, dated from June 1, 2013 through July 15, 2013 were missing temperature readings for the following dates and times:</p> | | | | |

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| | <p>Breakfast meal: June 6, 7, 10, 11, 17, 18, 19, 21, 24, 25, 26, 28, and 30, 2013</p> <p>Lunch meal: June 6, 7, 10, 11, 18, 19, 21, 24, 25, 26, 28, and 30, 2013</p> <p>Supper meal: June 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 26, 27, 29, and 30, 2013</p> <p>Breakfast meal: July 1, 2, 4, 5, 9, 10, and 11, 2013</p> <p>Lunch meal: July 1, 2, 4, 5, 9, 10, and 11, 2013</p> <p>Supper meal: July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, and 14, 2013</p> <p>Review of the current facility policy, dated 10/2/2008, provided by the Administrator on 7/16/13 at 3:50 p.m., titled "Food Temperatures on Service Line", included, but was not limited to, the following:</p> <p>"Policy: Foods will be served at proper temperature to ensure food safety.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Wash, rinse and sanitize a dial face thermometer with alcohol wipe. Re-sanitize the thermometer after each use. 2. Insert thermometer into center of product. Allow time for stabilization. | | | |

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| | <p>Wait until there is no movement for 15 seconds. Several reading may be required to determine hot and cold spots.</p> <p>3. Record reading on "Food Temperature Record" form at beginning of tray line and end of tray line. If temperatures do not meet acceptable serving temperatures, reheat the product or chill the product to the proper temperature. Take the temperature of each pan of product before serving..."</p> <p>This federal tag relates to Complaint number IN00132362.</p> <p>3.1-21(a)(2)</p> | | | | | | |

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| F000456 SS=E | <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review, and interview, the facility failed to ensure two electric Hoyer lifts were maintained in a safe operating manner to ensure residents who required the use of a Hoyer lift to get out of bed could be transferred as desired for 3 of 3 residents reviewed for Hoyer lift transfers in a sample of 8. (Resident #'s C, B, and F) This had the potential to affect 6 of 6 residents residing in the building requiring the need for a Hoyer lift for transfers.</p> <p>Findings include:</p> <p>During an observation with CNA #2 on 7/15/13 at 6:30 a.m., there were 2 electric Hoyer lifts and one mechanical Hoyer lift in the building. Both electric Hoyer lifts were charged and in working order. CNA #2 indicated the charger for the Hoyer lifts had not been in working order the previous week and the Hoyer lifts could not be used for several days. She indicated the mechanical lift was rarely used.</p> <p>During interviews on the following dates and times, resident concerns were</p> | F000456 | <p>1. Resident B, C and F incurred no negative outcome. The Hoyer lift and the chargers are now functioning properly. 2. All residents who utilize the Hoyer lift for transfers have the potential to be affected. The Hoyer lift and the chargers are now functioning properly. 3. The facility has purchased extra chargers. In the future, should the hoyer lift or the charger malfunction the staff is to alert the DON immediately who will then assess the needs of those residents who require Hoyer transfers and an alternate transfer process will be initiated, as warranted. All staff has been re-educated on what to do in the future should there be mechanical failure of the hoyer lift or its chargers. 4. The DON or her designee will monitor to ensure the Hoyer lift and the chargers are functioning properly daily on scheduled days of work daily for 2 weeks, three times a week for 2 weeks and then weekly until compliance is maintained for 6 consecutive months. (See Attachment 1)Should concerns be observed, re-education shall be provided. The results of said observations will be reviewed during the facility's quarterly QA</p> | 08/02/2013 | | | |

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| | <p>identified in regards to not having a Hoyer lift in working order to ensure safe resident transfers out of bed. Each resident interviewed below was identified as alert, oriented, and interviewable on a list provided by the Administrator on 7/15/13 at 8:25 a.m.</p> <p>During an interview on 7/15/13 at 1:45 p.m., Resident #F was up in her chair in her room. She indicated she had been unable to get out of bed on "Monday, Tuesday, and Wednesday" of the last week (July 8, 9, and 10, 2013) because the Hoyer lift was not working. She indicated the Hoyer lift was in working order by Wednesday afternoon, but it was not working until the time that she usually would have went back to bed, so she did not get up. She indicated she is usually out of bed for 5 to 7 hours a day. She indicated the mechanical lift was not used because it had a "weight limit" and was not secure.</p> <p>During an interview on 7/15/13 at 2 p.m., Resident #C was up in her wheelchair in her room watching television. She indicated she had been unable to get out of bed at least 3 days the previous week because there was no Hoyer lift in working order available. She indicated she preferred to be up in her wheelchair during the day and did not like staying in</p> | | meetings and the plan adjusted accordingly, if warranted. | | | | |

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| | <p>bed.</p> <p>During an interview on 7/15/13 at 2:20 p.m., Resident #B was up in her wheelchair in her room watching television. She indicated there had been a problem the previous week with the Hoyer lift not working and she had been unable to get out of bed as she desired to go smoke. She indicated she had become upset by this and insisted the staff transfer her manually from her bed to her wheelchair. She indicated the staff were supposed to use a Hoyer lift to transfer her, but one was not available for use.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 7/15/13 at 2:55 p.m., additional information was requested related to the Hoyer lifts not being operable the previous week.</p> <p>During an interview on 7/15/13 at 2:55 p.m., the DoN indicated there had been a problem with the Hoyer lifts not being in working order the previous week. She indicated the facility had previously had only one charger for both electric Hoyer lifts in the facility. She indicated the charger stopped working on 7/7/13 (a Sunday), but both Hoyers had a partial charge that could be used for some residents until it became depleted on</p> | | | | |

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| | <p>Monday 7/8/13. She indicated new chargers for the lifts had been ordered on 7/8/13 and arrived at the facility sometime on Wednesday July 10, 2013. This indicated a time period of at least 2 days that an electronic Hoyer lift was not available for use as needed.</p> <p>This federal tag relates to Complaint numbers IN00132362 and IN00132363.</p> <p>3.1-19(bb)</p> | | | |