

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  01/02/2014
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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 Complaint IN00141101.</p> <p>Complaint IN00141101 - Substantiated with findings at F309.</p> <p>Survey Dates: 1/2/2014</p> <p>Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180</p> <p>Survey team: Tina Smith-Staats, RN, TC Ginger McNamee, RN Toni Maley, BSW</p> <p>Census Bed Type: SNF/NF: 9 SNF: 47 Total: 56</p> <p>Census Payor Type: Medicare: 5 Medicaid: 47 Other: 4 Total: 56</p> <p>Sample: 5</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p>	F000000		
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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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	Quality review completed by Debora Barth, RN.			



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	<p>congestive heart failure.</p> <p>Resident #D had a current ,12/23/13, order to discontinue her previous Nystatin powder order. The new order indicated to begin Nystatin powder to the back and abdominal fold at 6:00 p.m. each day and use Nystatin Cream to the back and abdominal fold at 6:00 a.m. each day.</p> <p>Review of Resident #D's Medication Administration Record for December 2013 indicated Resident #D did not receive either Nystatin powder or Nystatin cream on 12/23/13, 12/24/13, 12/25/13, 12/26/13, 12/27/13 and 12/28/13 (a period of 6 days). The back side of the record where information regarding missed treatments was to be documented was blank.</p> <p>During a 1/2/14, 12:45 p.m. interview, the Administrator indicated the following: Resident #D was out of medication and couldn't get it because of some insurance reason. "We had to work on it." She also indicated the nursing staff told the Administrator the pharmacy kept saying it would be in the tote but it wasn't there. The staff called the Administrator on Christmas day because the medication still was</p>		<p>practicable</p> <p>physical, mental, and psychosocial well-being, in accordance with the</p> <p>comprehensive assessment and plan of care.</p> <p>Resident #D treatment medication supply has been</p> <p>reviewed and all prescribed treatment medications are readily available in the</p>				

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	<p>not available and the facility paid for the medication at a local pharmacy that day.</p> <p>The Administrator did not know why staff did not document giving medication on that day after the facility acquired the medication. On 12/27/13, the facility educated the nursing staff regarding medication availability and the process to notify the Administrator to obtain needed medication.</p> <p>During a 1/2/14, 1:30 p.m. interview, the Director of Nursing (DoN) indicated she was unable to find the wound care sheet for Resident #D's back rash. The wound nurse was on personal leave and may have some information regarding the wound sheet. The DoN indicated Resident #D's skin was currently much improved. The DoN indicated she did not know why the staff did not document administration of Nystatin powder or cream from 12/23/13 to 12/28/13 when the medication became available on 12/25/13. Additionally she indicated staff should document on the back of the Medication Administration Record when medication is not available.</p> <p>A current, undated, facility policy titled</p>		<p>facility. Resident #D incurred no negative outcome. All residents who have prescribed physician orders for treatments have the potential to be affected. The medical records</p> <p>and treatment medications of all residents who have physician ordered</p> <p>treatments have been reviewed and all treatment medications are readily</p> <p>available in the facility. The facility policy and procedure for Medication</p> <p>Unavailable for Administration was reviewed and no changes</p>				

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	<p>"Medication Unavailable For Administration", which was provided by the Administration on 1/2/14 at 3:00 p.m., indicated the following: "In the course of passing medication, should a medication be out or unavailable for administration, the licensed nurse or QMA is responsible to do the following: ...if when contacting the pharmacy you are informed of a situation which will delay or complicate delivery (for example, the medication has recently been filled and it is too soon for it to be refilled; the medication is not 'covered' etc.) contact administrative nursing/DON to determine how to proceed and to ensure that you have notified them that the resident did not (or will not) receive the medication as ordered until further corrective action is taken. -ensure that information regarding the medication not administered, status of notification/communication with the pharmacy, and the anticipated arrival is communicated..."</p> <p>3.1-37(a)</p>		<p>were made.All nurses have been re-educated on the  policy and procedure. Should medication/supplies be unavailable after following  established procedure, the applicable nurse is responsible to notify  administration in an effort to secure needed medication/supplies to follow  orders in place.The DON or her designee will monitor to ensure  that physician prescribed treatment medications are available in the facility</p>		

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			<p>on scheduled days of work daily via aforementioned reporting from nursing of</p> <p>any medications/supplies reported as unavailable and via audit/observation of</p> <p>at least 4 residents weekly for 2 weeks, 4 residents twice weekly for 2 weeks,</p> <p>then 4 residents weekly thereafter until compliance is maintained for 6</p> <p>consecutive months. Should concerns be observed, re-education will be provided.</p>	

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			<p>Results of aforementioned ongoing nurse reporting and weekly observations and</p> <p>any corrective actions taken will be discussed during the facility's quarterly</p> <p>QA meetings and the plan adjusted accordingly, as warranted.</p>	

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