

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  02/10/2012
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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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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 6, 7, 8, 9, and 10, 2010</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Survey team: Donna M. Smith, RN, TC Toni Maley, BSW Gina Berkshire, RN Dorothy Watts, RN</p> <p>Census bed type: SNF: 14 SNF/NF: 56 Total: 70</p> <p>Census payor type: Medicare: 7 Medicaid: 58 Other: 5 Total: 70</p> <p>Stage 2 sample: 38</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</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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	Quality review completed 2/15/12 Cathy Emswiller RN			

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified related to a breast lump found for 1 of 1 resident reviewed in a sample of 38. (Resident #48)</p> <p>Findings include:</p>	F0157	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and	03/05/2012			

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	<p>1. Resident #48's record was reviewed on 2/08/12 at 9:34 a.m. The resident's diagnoses included, but were not limited to, hypertension, microcytic anemia, anxiety, and multiple sclerosis. The significant change minimum data set assessment, dated 1/03/12, indicated the resident's BIMS (Base Interview Mental Status) was 15 indicating the resident was cognitively intact. The nurse's notes indicated on 1/20/12 (no time indicated) the resident had stated she had found a lump under her left breast in the armpit area. The writer indicated the lump was present and would continue to monitor.</p> <p>The Nurse Practitioner's progress note, dated 2/08/12, indicated no information related to a chest area. No information was indicated concerning physician notification of the breast lump or further follow up.</p> <p>2. On 2/10/12 at 8:20 a.m. during an interview, LPN #6, who indicated he was the charge nurse today, indicated he was unaware of a lump found under Resident #48's left breast/armpit. He also indicated the physician should had been notified of the breast lump.</p>		<p>federal law. Please accept this plan of correction as our credible allegation of compliance. F 157 I. The physician of resident #48 has been notified in regard to the lump noted under the left breast of the resident. Any further directives given by the physician will be followed accordingly. II. As all residents could potentially be affected by this practice, nurse's notes from the past 30 days were reviewed to ensure that any condition(s) addressed had been reported to the physician in a timely manner. III. As a means to ensure ongoing compliance with timely physician notification, licensed nursing staff shall receive inservice training of resident change in condition. Following inservice training, administrative nursing staff shall be responsible to review nurse's notes at least three times weekly in an effort to confirm timely physician notification of resident change in condition. Should non-compliance be noted, applicable staff will be re-educated and/or disciplined as warranted. IV. As a means of quality assurance, results of the aforementioned administrative audits and corrective actions taken (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis.</p>				

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	<p>3. The "PHYSICIAN &amp; FAMILY NOTIFICATION PROCEDURE" policy was provided by the Nursing Consultant on 2/10/12 at 10:30 a.m. This current policy indicated the following:</p> <p>"PURPOSE: To keep the physician, resident and family apprased of all condition changes.</p> <p>PROCEDURE:</p> <p>Telephone: ...2. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan....."</p> <p>3.1-5(a)</p>			
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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure all allegations of abuse or mistreatment were reported to the Indiana State</p>	F0225	F 225 I. Please note that the allegation made by Resident #17 was investigated and addressed with the applicable staff member at the time of the incident. The	03/05/2012			

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	<p>Department of Health for 1 of 8 residents reviewed for implementation of the facilities abuse policy in a stage 2 sample of 38 (Resident #17).</p> <p>Findings Include:</p> <p>1.) Resident #17's clinical record was reviewed on 2/10/12 at 11:40 a.m.</p> <p>Resident #17's current diagnoses included, but were not limited to, dementia and hypertension.</p> <p>During a 2/7/12, 12:36 p.m., family interview, Resident #17's family member indicated there had been a problem in September/October 2011, CNA #14, spoke rough or rude with the resident.</p> <p>Review of a 9/20/11, "Report of Concern" indicated the family of Resident #17 had the following concern: "Family reported staff's tone was rough/rude to res [resident]."</p> <p>During a 2/8/11, 11:15 a.m., interview, The Social Service Director indicated he had received a "Report of Concern" from Resident #17's family on 9/20/11. The complaint had indicated CNA #14 had been rude when speaking to Resident #17. He indicated an investigation had been</p>		<p>allegation was reported to ISDH survey team at the time of survey.</p> <p>II. As all residents could potentially be affected by this practice, all reports of concern from the past six months have been reviewed to ensure any which meet the reportable guidance have been reported accordingly. As a means to ensure ongoing compliance with reporting allegations of abuse or mistreatment of residents, department heads have been inserviced in regard to I. reportable unusual occurrence guidance to ensure clarity. Following inservice training, each report of concern shall be reviewed by the Administrator upon receipt in an effort to confirm appropriate immediate intervention, investigation, corrective action and necessary reporting has been conducted. Additionally, said reports shall be reviewed by the nurse consultant during at least weekly visits to the facility to confirm continued compliance with reporting. II. As a means of quality assurance, the aforementioned audits conducted by the Administrator and Nurse Consultant and any corrective actions taken (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis.</p>		

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	<p>completed and CNA #17 was determined to have a rough tone of voice. CNA #14 had been educated regarding voice tone. He indicated He did not consider "rude" to be abuse. The Social Service Director indicated the facility had not reported the concern to the Indiana State Department of Health because he had not considered it to be an allegation of abuse or a reportable unusual occurrence.</p> <p>2.) Review of a current, 1/06, facility policy titled, "Abuse Prohibition, reporting and Investigation Policy and Procedure", which was provided by the Administrator on 2/8/11 at 10:55 a.m., indicated the following: "Verbal Abuse-Episodes of oral, written and/or gestured language that includes disparaging and derogatory remarks to the residents."</p> <p>Review of a current, undated, facility policy titled, "Procedure -Resident Abuse" which was provided by the Administrator on 2/8/11 at 10:55 a.m., indicated the following: "...The Administrator or Director of Nursing is responsible to notify the following agencies, as outline in the nursing Policy and Procedure Manual "Unusual Occurrences Reporting Policy and Procedure": Indiana State</p>						

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	<p>Department of Health..."</p> <p>Review of a current, 2/10. facility policy titled "Reporting Unusual Occurrences to the State", which was provided by the Administrator on 2/10/12 at 2:48 p.m., indicated the following: "...The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source...are immediately to the Administrator of the facility and to other officials as applicable."</p> <p>3.1-28(c)</p>			
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F0226 SS=D	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview and record review, the facility failed to ensure employees reported all allegations of abuse to the Administrator immediately following the allegation (Resident #56) and the facility failed to ensure all allegations of abuse were reported to the Indiana State Department of Health (Resident #17) for 2 of 8 residents reviewed for implementation of the facilities abuse policy in a stage 2 sample of 38.</p> <p>Findings Include:</p> <p>1.) Resident #17's clinical record was reviewed on 2/10/12 at 11:40 a.m.</p> <p>Resident #17's current diagnoses included, but were not limited to, dementia and hypertension.</p> <p>During a 2/7/12, 12:36 p.m., family interview, Resident #17's family member indicated there had been a problem in September/October 2011, CNA #14, spoke rough or rude with the resident.</p> <p>Review of a 9/20/11, "Report of</p>	F0226	<p>F 226 I. Please note that the allegation made by Resident #17 was investigated and addressed with the applicable staff member at the time of the incident. The allegation was reported to ISDH survey team at the time of survey. The allegation made by Resident #91 was investigated immediately and addressed with the applicable staff and residents. The allegation was reported to ISDH at the time of the survey. The involved staff member was re-educated as to definition(s) of abuse and facility policy in regard to reporting. II. As all residents could potentially be affected by this practice, all reports of concern from the past six months have been reviewed to ensure any which meet the reportable guidance have been reported according to policy. III. As a means to ensure ongoing compliance with employees reporting allegations of abuse or mistreatment of residents to administrative staff, the facility will ensure all employees are inserviced relative to reporting all allegations of abuse or mistreatment to administrative staff immediately. The administrator upon receiving the report of abuse or mistreatment will ensure all such allegations</p>	03/05/2012	

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	<p>Concern" indicated the family of Resident #17 had the following concern: "Family reported staff's tone was rough/rude to res [resident]."</p> <p>During a 2/8/11, 11:15 a.m., interview, The Social Service Director indicated he had received a "Report of Concern" from Resident #17's family on 9/20/11. The complaint had indicated CNA #14 had been rude when speaking to Resident #17. He indicated an investigation had been completed and CNA #17 was determined to have a rough tone of voice. CNA #14 had been educated regarding voice tone. He indicated He did not consider "rude" to be abuse. The Social Service Director indicated the facility had not reported the concern to the Indiana State Department of Health because he had not considered it to be an allegation of abuse or a reportable unusual occurrence.</p> <p>2.) Resident #91's clinical record was reviewed on 2/9/12, 10:30 a.m.</p> <p>Resident #91's current diagnoses included, but were not limited to, hypertension, anxiety, acute respiratory failure and bipolar disorder.</p>		<p>are reported to the Indiana State Department of Health as per the facility's abuse policy. Additionally, said reports shall be reviewed by the nurse consultant during at least weekly visits to the facility to confirm continued compliance with reporting. I. As a means of quality assurance, the aforementioned audits conducted by the Administrator and Nurse Consultant and any corrective actions taken (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis.</p>				

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	<p>During a 2/18/12, 9:40 a.m. interview, Resident #91 indicated she was not afraid for her self but instead had concerns for dependent people who could not speak for themselves. Resident #91 additionally indicated about three weeks ago to a month ago, CNA #16 had yelled at Resident #56 when his chair alarm repeatedly went off. CNA #16 yelled for Resident #91 to "Sit down! I don't have time for this!" Then CNA #16 had slammed Resident #56's door. Resident #91 indicated she had expressed her concerns to RN #7 at that time.</p> <p>During a 2/8/12, 2:03 p.m., interview, RN #7 indicated Resident #91 had reported her concern for Resident #56 about a month ago. He indicated he had counseled CNA #16 regarding her behavior. He indicated sometimes Resident #91 "makes up stories." He indicated facility policy required all allegations to be reported to the DON or the direct supervisor immediately. RN #7 indicated he may have told his supervisor or the DON but he did not recall.</p> <p>During a 2/8/12, 2:07 p.m., LPN #18, indicated he was second shift charge, was not told of any allegation made by Resident #19 about Resident #56.</p>			
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	<p>During a 2/8/12, 2:10 p.m., interview, the DoN indicated RN #7 had not notified her of the above allegation.</p> <p>During a 2/8/12, 4:00 p.m. interview the DoN indicated an investigation was being completed regarding the allegation that CNA #16 had yelled at Resident #56 and slammed his door. The DoN indicated CNA #16 was suspended pending investigation and RN #7 had received disciplinary action for failure to follow facility policy and report immediately all allegations of abuse.</p> <p>3.) Resident #56's record was reviewed on 2/10/12 at 1:00 p.m. The resident had a current 11/22/11, quarterly Minimum Data Set Assessment (MDS) which indicated the resident rarely or ever made independent decisions and had a diagnoses of dementia. On 2/7/12 at 10:00 a.m., Resident #56 was assessed for his ability to communicate. Due to his non-interviewable status Resident #56 was not interviewed regarding the above allegation.</p> <p>4.) Review of a current, 1/06, facility policy titled, "Abuse Prohibition, reporting and Investigation Policy and</p>			
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	<p>Procedure", which was provided by the Administrator on 2/8/11 at 10:55 a.m., indicated the following: "Verbal Abuse-Episodes of oral, written and/or gestured language that includes disparaging and derogatory remarks to the residents."</p> <p>Review of a current, undated, facility policy titled, "Procedure -Resident Abuse" which was provided by the Administrator on 2/8/11 at 10:55 a.m., indicated the following: "...The Administrator or Director of Nursing is responsible to notify the following agencies, as outline in the nursing Policy and Procedure Manual "Unusual Occurrences Reporting Policy and Procedure": Indiana State Department of Health..."</p> <p>Review of a current, 2/10. facility policy titled "Reporting Unusual Occurrences to the State", which was provided by the Administrator on 2/10/12 at 2:48 p.m., indicated the following: "...The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source...are immediately to the Administrator of the facility and to other officials as applicable."</p>						

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F0241 SS=E	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to serve meals to dependent residents in a way that preserved and promoted dignity for 3 of 3 meals observed for dignity while dining. (12/6/12, 12/9/12 and 12/10/12 lunches). This deficient practice had the potential to impact 9 of 9 residents who dined in the assisted dining area and required staff assistance for mobility to and from the dining room. (Resident #'s 8, 56, 43, 1, 73, 22, 31, 30, and 49)</p> <p>Finding Include:</p> <p>During a 2/6/12, 11:58 a.m. to 12:30 p.m., lunch meal observation nine residents sat in the assisted dining area. The residents sat facing the table as if ready to dine. The dining area was devoid of any interactive or manipulative materials. There was no form of stimulation offered to the residents. Staff did not converse with residents nor did residents converse with one another. The residents sat facing the tables. Some residents closed their eyes and put their heads down on and off during the 32 minute period. At 12:30 p.m. the facility</p>	F0241	F 241 I. Compliance with appropriate transportation of dependent residents to the assist dining room which resulted in residents waiting for an extended period of time prior to meal service, was addressed with the nursing staff during the survey process. II. As all residents in the assisted dining area could potentially be affected by this practice, the following actions shall be taken: III. As a means to ensure ongoing compliance with serving meals to dependent residents in a way that preserves and promotes dignity, the facility has reviewed and revised the assist dining room seating arrangement and means to enhance the dining experience in the assist dining room, including elements of sensory stimulation while awaiting meal delivery. Applicable staff will be inserviced accordingly. Following revision of meal service in the assist dining room, meal observations will be made at least three times weekly by administrative staff to confirm continued compliance with provision of meals in a manner to preserve and promote dignity while dining. Should concerns be noted, immediate corrective action shall be taken and applicable staff	03/05/2012			

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	<p>began to served meal trays to the assisted dining area.</p> <p>During a 2/9/12, 12:05 p.m. to 12:38 p.m., lunch meal observation, nine residents sat in the assisted dining area. The resident sat facing the table as if ready to dine. The dining area was devoid of any interactive or manipulative materials. There was no form of stimulation offered to the residents. Staff did not converse with residents nor did residents converse with one another. The residents sat facing the tables. Some residents closed their eyes and put their heads down on and off during the 33 minute period. At 12:38 p.m., the facility began to serve meals to the residents in the assisted dining area.</p> <p>During a 2/9/11, 12:30 p.m., interview, the Director of Nursing indicated 10 residents consumed meals in the assisted dining area. She indicated only one (Resident #6) of the ten residents could independently transport herself to the dining room. The DoN indicated the other 9 residents were dependent on staff assistance for mobility to and from the dining area.</p> <p>During a 2/10/12, 12:00 p.m. lunch meal observation, 4 residents were</p>		<p>addressed/re-educated as warranted. IV. As a means of quality assurance, results of the aforementioned observations and any corrective actions taken (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis. Addendum: The meal observations will include all three meals.</p>		

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	<p>seated in the assisted dining area awaiting their meal. By 12:15 p.m., the remaining 6 residents were seated facing their tables in the assisted dining area. The dining area was devoid of any interactive or manipulative materials. There was no form of stimulation offered to the residents. Staff did not converse with residents nor did residents converse with one another. The residents simply sat facing the tables. Some residents closed their eyes and put their heads down on and off during the 42 minute period. At 12:42 p.m., the facility began to serve meals to the residents in the assisted dining area.</p> <p>During a 12/10/12, 11:58 a.m., interview, The Food Services Supervisor indicated the lunch meal was scheduled to be served in the main dining room, which included the assisted dining area, at 12:00 p.m.</p> <p>Review of an undated, facility form, titled "Meadow Brook Rehabilitation Center Meal Service Times", which was provided by the Administrator in 2/6/12 at 9:53 a.m., indicated the following: "Lunch-Dining Room-12:00 p.m."</p> <p>Review of an undated, current, facility</p>						

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	<p>seating chart, which was provided by the Admissions Co-coordinator on 2/10/12 at 12:45 p.m., indicated 10 facility residents had assigned seating in the assisted dining area.</p> <p>3.1-3(t)</p>			
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F0248 SS=D	<p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure cognitively impaired, dependent resident were offer individualized activity programs for 1 of 3 dependent residents reviewed for activity programing in a stage 2 sample of 38. (Resident #20).</p> <p>Findings Include:</p> <p>1.) Resident #20's record was reviewed on 2/9/12, at 2:50 p.m.</p> <p>Resident #20's current diagnoses included, but were not limited to, Schizophrenia Paranoid, blind, depression and dementia with psychotic features.</p> <p>Resident #20 had a 1/2/12, current care plan problem/need regarding him disliking to leave the room. This problem originated 1/9/11. The goal for this problem was for the resident to participate in the restorative program. Approaches to this problem included, but were not limited to, offer one to one activities and make an effort to include the resident in</p>	F0248	<p>F 248 I. Resident #20 has been interviewed by activity staff in an effort to identify specific interests, and the activity program revised accordingly on the basis of the interview. In an effort to identify other residents who might be affected, all cognitively impaired, dependent residents have been identified and will be interviewed by I. activity staff in an effort to identify specific interests and his/her activity program will be individualized/revised accordingly.</p> <p>II. As a means to ensure ongoing compliance with individualized activity programs for cognitively impaired, dependent residents, the Activity Director shall be responsible to evaluate efficacy of programming via resident response and revise the plan should concern with efficacy be noted. The Director shall provide a summary of programming resident response to the Administrator on a monthly basis.</p> <p>III. As a means of quality assurance, results of the aforementioned monthly evaluation and any corrective actions taken to improve programming (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis.</p>	03/05/2012			

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	<p>ongoing activate program.</p> <p>Resident #20 had a 1/13/12, Activity Quarterly Review which indicated the resident received one to one activities 2 times a week and the current goal would be continued.</p> <p>Resident #20 was observed in his room, on his bed, without any form of stimulation, during the following dates and times: 2/6/12-2:00 p.m., 2/7/12-1:30 p.m. 2/8/12-10:00 a.m., 1:45 p.m., 2:35 p.m. 2/9/12-9:25 a.m., 1:55 p.m., 2:50 p.m. 2/10/12-10:06 a.m.</p> <p>Resident #20 was not observed out of his room at any time during the survey process on 2/6/12 from 10 a.m. to 4 p.m., on 2/7/12 from 8 a.m. to 4 p.m., on 2/8/12 from 8 a.m. to 4 p.m., on 2/9/12 from 8 a.m. to 4 p.m., and on 2/10/12 from 8 a.m. to 4 p.m.</p> <p>During a 2/10/12, 9:40 a.m., interview, the Activity Director indicated Resident #20 seldom left his room. She indicated she thought it was due to his blindness. She indicated Resident #20 had not left his room for activities in a long time. He had not left his room for activities</p>						

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	<p>during December 2011, January 2012 or February 2012 (2/1/12 to 2/10/12). The Activity Director indicated, Resident #20 had been offered one to one personalized activities two times a week until 2/8/12. She indicated although he had not attended any out of room activities in December 2012 she had not increased his one to one activities or updated his care plan when completing her 1/13/12 assessment. She indicated that prior to 2/8/12 no resident had received one to one activities more than 2 times per week.</p> <p>3.1-33(a)</p>			
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F0253 SS=E	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observations and interview, the facility failed to ensure a clean and sanitary environment related to resident's bedside tables and bathrooms, 2 of 3 shower rooms, the banister in the main dining room, and 1 of 1 beauty shop. This had the potential to impact 11 of 11 residents residing in the observed resident rooms. (Resident #'s 72, 27, 30, 48, 73, 78, 44, 99, 110, 42, and 68). This had the potential to impact 24 of 24 residents residing on the 200 and 600 halls. This deficient practice had the potential to affect 35 of 35 residents currently residing in the facility.</p> <p>Findings include:</p> <p>1. On 2/6/12 at 11:46 a.m. during Resident #72's room observation, the cove base was observed coming off around the corner of the shower. A squared 12 inch area around the ceiling sprinkler had been patched and had not been repainted.</p> <p>2. On 2/6/12 at 2:48 p.m. during Resident #27's room observation, the bathroom ceiling vent cover was observed hanging loose from the ceiling especially on one side of this</p>	F0253	F 253 I. 1. The covebase was repaired in the shower of Resident #72, as well as the patched area repainted. 2. The bathroom ceiling vent was reattached and screw placed to hold the vent secure in the room of Resident #27. 3. The floor mat in the room of Resident #30 has been replaced. 4. The covebase around the shower was repaired in the room of Resident #48, as well as the ceiling vent secured. The bedside table was replaced. 5. The gaps observed around pipes in the room of Resident #73 have been repaired. 6. The floor covering in the room of Resident #44 will be repaired and/or replaced. The vinyl flooring in the bathroom of Resident #44 will be repaired and/or replaced. 7. The bedside table in the room of Resident #99 has been replaced. 8. The ceiling vent in the room of Resident #110 has been secured. 9. The return vent cover in the room of Resident #42 has been secured. The hole in the wall above the chair rail in the room of Resident #68 has been repaired, as well as other damaged wall areas. The mat in use in room of Resident #30 has been replaced. The bedside table used by Resident #99 has been replaced. The panel in the beauty shop will be repaired and/or replaced. The ceiling fan	03/05/2012			

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	<p>vent where the screw was not fastened into the vent cover.</p> <p>3. On 2/6/12 at 2:52 p.m. during Resident #30's room observation, her floor mat next to her bed was observed with small to 1 inch torn areas mainly along the seams of the mat exposing the stuffing of the mat. The resident was presently observed in her bed.</p> <p>4. On 2/7/12 at 8:55 a.m. during Resident #48's room observation, the cove base around the shower corner was observed falling off of the wall. The ceiling vent in the bathroom was also observed loosely attached leaving a gap between the ceiling and the vent. Her bedside table was observed uneven and cracked all around the edge of this bedside table, which was being used by the resident.</p> <p>5. On 2/7/12 at 1:47 p.m. during Resident #73 and #78's room observation in the bathroom, the pipe hanging from the ceiling was observed with an open gap around the pipe. Behind the toilet another open area around the pipe from the wall to the toilet was observed.</p> <p>6. On 2/6/12 at 3:30 p.m. during Resident #44's room observation, an</p>		<p>has been cleaned. The frequency of cleaning fans throughout the facility has been increased to twice per month (previously once per month). · A covering has been placed on the light in the 200 Shower room. · The banisters in the main dining room have been thoroughly cleaned and placed on a routine cleaning schedule. · The ceiling vents in the 600 Shower room have been secured. 10. The common areas of the facility have been addressed and placed on routine cleaning schedules. I. In an effort to ensure the provision of housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior, house wide rounds were made by the Administrator and areas in need of repair identified. Work orders shall be completed and repairs scheduled accordingly. II. As a means to ensure ongoing compliance with the provision of a clean and sanitary environment, cleaning schedules have been reviewed and updated as necessary to ensure the frequency is sufficient and all areas are addressed. Additionally, the current process for the completion, delegation and execution of work orders has been reviewed to ensure timeliness of completion. The Administrator shall be responsible to make weekly house wide rounds to confirm compliance</p>	
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	<p>irregular torn area of the floor covering was observed under the outside leg of the resident's bed. This torn floor vinyl area measured 9 inch long and 6 inches at the widest point of this torn area. In the bathroom around the front of the toilet, the floor vinyl flooring was observed curling up with loose caulking also observed in this same area. During an interview at this same time, CNA #19 indicated one would fill out a form to notify maintenance of a problem in a resident's room.</p> <p>7. On 2/8/12 at 11:23 a.m. during medication pass, Resident #99's bedside table, which was being used, was observed with uneven, cracked areas around the outside border of the bedside table.</p> <p>8. On 2/8/12 at 11:45 a.m. during medication pass, Resident #110's bathroom ceiling vent was observed loosely hanging from the ceiling leaving a gap.</p> <p>9. On 2/9/12 at 9:30 a.m., the environmental tour was conducted with the Maintenance Supervisors and Housekeeping Supervisor. The following was observed:</p> <p>In Resident #42's room, the return</p>		<p>with the aforementioned cleaning schedules and will review work orders on a weekly basis to ensure the correct prioritization and completion of maintenance repairs. III. As a means of quality assurance, the aforementioned weekly rounds, review of completed work orders and any additional intervention required/executed (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis.</p>	

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	<p>vent cover was observed hanging loosely from the ceiling leaving a visible gap;</p> <p>In Resident #68's room , a hole in the wall above the chair rail was observed and measured an irregular, sized 3 inch long by 2 inch wide. On each side of the hole in the wall, an irregular lined scuffed areas were observed. At this same time during an interview, the Maintenance Supervisor and Housekeeping Supervisor indicated the areas were probably caused by the resident's rocking chair located in front of the hole and scuffed areas.</p> <p>Resident # 30's floor mat was again with the torn edges. During an interview at this same time, the Maintenance Supervisor indicated therapy would need to be notified of the mat's condition.</p> <p>Resident #99's bedside table was pointed out. During an interview at this same time, the Maintenance Supervisor indicated the table probably had water setting on it and warped the edges.</p> <p>In the Beauty shop the panel below the shampooing sink had an irregular dinner-plate sized area torn off of this panel. Also, the ceiling fan was observed with a layer of gray dust observed inside this fan. At this same</p>			
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	<p>time during an interview, the Housekeeping Supervisor indicated he would clean the fans in the facility 1 time a month.</p> <p>In the 200 shower room in one of the shower areas, there was no covering over the light.</p> <p>The banister in the main dining room was observed with a thin layer of light to dark gray loose dirt between the spindles of the banister.</p> <p>In the 600 shower room in each of the 3 shower areas, the ceiling vents were observed loosely attach resulting in visible gaps around them.</p> <p>10. On 2/9/12 at 12:10 p.m. during an interview, the Housekeeping Supervisor indicated he did not have a set schedule for the cleaning of the common areas. He indicated the common areas were to be checked by the staff during their room cleanings.</p> <p><b>3.1-19(f)</b></p>				

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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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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to provide a comprehensive care plan with specific interventions in the prevention and healing of a pressure ulcer for 1 of 1 resident who met the criteria for pressure ulcers in the Stage 2 sample of 39 residents. (Resident # 8)</p> <p>Findings include:</p> <p>Resident # 8's record was reviewed on 2/8/2012 at 9:16 a.m. The Resident's diagnoses included, but were not limited to, Diabetes Mellitus, Compression Fracture, Peripheral</p>	F0279	F 279 The comprehensive care plan of Resident #8 has been reviewed and revised to ensure appropriate directives to the staff in regard to care and treatment of the I. pressure ulcer, including but not limited to, the appropriate setting of the mattress in use. II. In an effort to identify all residents who could potentially be affected, all residents with open areas/skin conditions have been identified and their careplans reviewed and revised as necessary to ensure the care plan is individualized to any specific equipment in use and interventions appropriate for the individual resident. III. As a means to ensure ongoing compliance with provision of a comprehensive careplan with	03/05/2012			

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	<p><b>Vascular Disease.</b></p> <p>The Pressure Ulcer Flow Sheet indicated a Stage 2 pressure ulcer developed 12/7/2010 on the back/spine of Resident # 8 with the current staging dated 2/3/2012, indicated a healing Stage 3 pressure ulcer.</p> <p>Resident # 8's care plan problem/need was an open area to the thoracic spine. the care plan was initiated on 3/14/2011 and updated last on 6/14/2011. The approaches included, but were not limited to, provide a pressure redistribution mattress to bed, provide pressure redistribution cushion to wheel chair, assist with turning and repositioning every 2 hours.</p> <p>Resident #8 was observed on 2/8/2012 at 9:30 a.m. to be lying on her right side with the bed flat; the Low Air Loss Mattress control unit was set on 8.</p> <p>2/8/2012 at 10:15 a.m., in the 300 hall, CNA # 5, who was assigned to the residents hall, indicated she did not know how to adjust the mattress.</p> <p>2/8/2012 at 10:18 a. m., in the 300 hall, the other CNA #13 said,"we don't</p>		<p>specific interventions relative to the prevention and healing of a pressure ulcer, licensed nursing staff has received inservice training in regard to review and revision of the care plan with newly added equipment, revision of intervention(s), new physician orders, etc. Following said inservice, administrative nursing staff shall be responsible to review the care plans of those residents with pressure ulcers on a weekly basis to ensure the accuracy and clarity of the individual resident's care plan. Additionally, the nurse consultant shall be responsible to review the aforementioned care plans on visits conducted at least every two weeks, to ensure the care plan remains appropriate and to assess healing and/or lack thereof. Should concerns be noted, immediate corrective action and re-education shall be initiated. IV. As a means of quality assurance, the aforementioned administrative reviews as well as reviewed conducted by the nurse consultant and any corrective actions taken (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis and any interventions taken as a result as those reviews shall be reported to the quality assurance committee on a quarterly basis.</p>		

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	<p>adjust the mattress."</p> <p>On 2/8/2012 at 10:20 a.m., during interview, LPN # 3 indicated the mattress was provided by a contractor who had not given any information or instructions about the mattress settings. (LPN #3) said he did not know what the setting was supposed to be. He also indicated the treatment sheet did not indicate the mattress setting.</p> <p>2/8/2012 at 10:30 a.m. Resident #8's treatment for her stage 2 pressure ulcer located on her thoracic spine was observed. Before starting the dressing change, Charge Nurse # 6 and the DON pushed every button on the control unit to increase the setting from 8 to firm. After the dressing change, the mattress setting was returned to 8 by Charge Nurse # 6. At this time during an interview, the DON indicated the contractor established the setting when the mattress was delivered, which was presently on 8.</p> <p>Review of Resident #8's treatment sheet on 2/8/2012 at 10:00 a.m. indicated Low Air Loss Mattress. No instructions were noted on the treatment sheet indicating appropriate mattress settings for Resident # 8.</p>			
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	<p>On 2/8/2012 at 1:30 p.m., Resident # 8 was observed lying in her bed on her back with air mattress setting at 8.</p> <p>On 2/9/2012 at 2:05 p.m., the DON located the IQ Low Air Loss Mattress instruction manual which advised the comfort setting should be set according to the individual patient's weight. This operation manual for the IQ Low Air Loss Mattress indicated a patient with the weight of 100-125 pounds should have a comfort setting of 4. The manual also indicated the mattress control unit features Instant In- Service, a built in audio component that provides users with immediate instructions on the proper use of the IQ Medical Mattress.</p> <p>The weekly weight record for 2/7/2012 indicated Resident # 8 weight was 111.5 pounds.</p> <p>Interview on 2/9/12 at 2:40 p.m., the DON indicated the hospice company had ordered the IQ Low Air Loss Mattress for Resident # 8. The DON also indicated the air mattress is now set on 4.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>			
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F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's care plan was updated when an assessment was completed to indicate the current plan did not meet the residents needs for 1 of 3 residents reviewed for current activity care plans in a stage 2 sample of 38. (Resident #20).</p> <p>Findings Include:</p> <p>1.) Resident #20's record was reviewed on 2/9/12 at 2:50 p.m.</p> <p>Resident #20's current diagnoses included, but were not limited to, Schizophrenia Paranoid, blind, depression and dementia with</p>	F0280	F 280 I. Resident #20 was interviewed in regard to interests and the activity programming and careplan revised accordingly. In an effort to identify other residents who might be affected, other residents known to seldom leave their rooms and/or have limited participation in group activities have been identified and will be interviewed by activity staff in an effort I. to identify specific interests and his/her activity program shall be individualized and corresponding comprehensive care plan revised accordingly. II. As a means to ensure ongoing compliance with the care plan being updated when an assessment is completed to indicate the plan does not meet the needs for a resident in regard to activities, the Activity Director	03/05/2012
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	<p>psychotic features.</p> <p>Resident #20 had a 1/2/12,current care plan problem/need regarding him disliking to leave the room. This problem originated 1/9/11.</p> <p>Resident #20 had a 1/13/12, Activity Quarterly Review which indicated the resident received one to one activities 2 times a week and the current goal would be continued.</p> <p>Resident #20 was observed in his room, on his bed, without any form of stimulation, during the following dates and times: 2/6/12-2:00 p.m., 2/7/12-1:30 p.m. 2/8/12-10:00 a.m., 1:45 p.m., 2:35 p.m. 2/9/12-9:25 a.m., 1:55 p.m., 2:50 p.m. 2/10/12-10:06 a.m.</p> <p>Resident #20 was not observed out of his room at any time during the survey process on 2/6/12 from 10 a.m. to 4 p.m., on 2/7/12 from 8 a.m. to 4 p.m., on 2/8/12 from 8 a.m. to 4 p.m., on 2/9/12 from 8 a.m. to 4 p.m., and on 2/10/12 from 8 a.m. to 4 p.m.</p> <p>During a 2/10/12, 9:40 a.m., interview, the Activity Director indicated Resident #20 seldom left his</p>		<p>shall be responsible to evaluate efficacy of programming via resident response and revise the programming accordingly should concern be noted. The Activity Director shall provide a summary of programming for those identified and efficacy thereof to the Administrator on a monthly basis. III. As a means of quality assurance, results of the aforementioned monthly evaluation and any corrective actions taken to improve programming and care planning for the individual resident (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis.</p>				

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	<p>room. She indicated she thought it was due to his blindness. She indicated Resident #20 had not left his room for activities in a long time. He had not left his room for activities during December 2011, January 2012 or February 2012 (2/1/12 to 2/10/12). The Activity Director indicated, Resident #20 had been offered one to one personalized activities two times a week until 2/8/12. The activity Director indicated although he had not attended any out of room activities in December 2012 she had not increased his one to one activities or updated his care plan when completing her 1/13/12 assessment.</p> <p>3.1-25(d)(2)(B)</p>			
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F0314 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary treatment and services to promote the healing of a pressure ulcer for 1 of 1 residents who met the criteria for pressure ulcers in the Stage 2 sample of 38 residents. (Resident #8)</p> <p>Findings Include:</p> <p>Resident # 8's record was review on 2/8/2012 at 9:16 a.m. The resident's diagnoses included, but were not limited to, Diabetes Mellitus, Compression Fracture, Peripheral Vascular Disease.</p> <p>The Pressure Ulcer Flow Sheet indicated a Stage 2 pressure ulcer developed 12/7/2010 on the back/spine of Resident # 8 with the current staging dated 2/3/2012, indicated a healing Stage 3 pressure ulcer.</p>	F0314	F 314 I. The care and treatment for the pressure ulcer of Resident #8 has been reviewed and specific instruction as to the setting/use of the low air loss mattress as well as all appropriate interventions have been clearly addressed on the resident's records, including the resident care plan, treatment administration record, medication administration record, etc. II. All residents with a current open area or skin condition have been identified and corresponding medical records (e.g., care plan, medication administration record, treatment administration record, etc.) have been reviewed and revised as necessary to ensure that necessary care and any special instruction(s) in regard to equipment and use are clearly addressed for applicable staff and staff has been educated accordingly. As a means to ensure ongoing compliance with interventions, prevention, and healing of pressure ulcers, licensed nursing staff has received inservice training in regard to ensuring clarity in any	03/05/2012			

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	<p>Resident #8's care plan problem/need was pressure ulcer risk due to: bed fast or in a wheel chair all or most of the time. The care plan was last updated on 12/9/2011 .The approaches include, but not limited to, head to toe skin assessment at least weekly by a licensed nurse, pressure redirecting mattress to bed, pressure redirecting cushion to chair .encourage and assist resident with turning and repositioning every 2 hours.</p> <p>Resident # 8's care plan problem/need was an open area to the thoracic spine. The care plan was initiated on 3/14/2011 and updated last on 6/14/2011. The approaches included, but were not limited to, provide a pressure redistribution mattress to bed, provide pressure redistribution cushion to wheel chair, assist with turning and repositioning every 2 hours.</p> <p>Resident #8 was observed on 2/8/2012 at 9:30 a.m. to be lying on her right side with the bed flat; the IQ Low Air Loss Mattress control unit was set on 8.</p> <p>Observed Resident # 8 on 2/8/2012</p>		<p>specific intervention/instruction to be followed by nursing staff in regard to pressure ulcer care (e.g., settings of specialized mattresses, use of specific equipment, etc.) and communication of the same to applicable I. nursing staff. Following said inservice training, administrative nursing staff shall be responsible to monitor on a weekly basis care being provided to those residents of the facility with open areas/skin conditions in an effort to verify continued compliance with correct execution of ordered interventions in a manner to promote healing and to prevent further skin breakdown, as well as communication of specific instruction to all applicable staff (e.g., mattress setting). Should concerns be noted, corrective action shall be taken, including re-education and/or disciplinary action, if warranted. II. As a means of quality assurance, the aforementioned weekly reviews conducted by administrative nursing and corrective interventions taken (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis. Addendum: Care being monitored will include all three shifts.</p>				

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	<p>at 1:30 p.m., lying in her bed on her back with air Mattress set at 8.</p> <p>2/8/2012 at 10:15 a.m., in the 300 hall, CNA # 5, who was assigned to the resident's hall, indicated she did not know how to adjust the mattress.</p> <p>2/8/2012 at 10:18 a. m., in the 300 hall, the other CNA # 13 said,"we don't adjust the mattress."</p> <p>On 2/8/2012 at 10:20 a.m., during interview, LPN # 3 indicated the mattress was provided by a contractor who had not given any information or instructions about the mattress settings. (LPN #3) said he did not know what the setting was supposed to be. He also indicated the treatment sheet did not indicate the mattress setting.</p> <p>2/8/2012 at 10:30 a.m. Resident # 8's treatment for her stage 2 pressure ulcer located on her thoracic spine was observed. Before starting the dressing change, Charge Nurse # 6 and the DON pushed every button on the control unit to increase the setting from 8 to firm. After the dressing change, the mattress setting was returned to 8 by Charge Nurse # 6. At this time during an interview, the DON indicated the contractor</p>						

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	<p>established the setting when the mattress was delivered, which was presently on 8.</p> <p>Review of Resident #8's treatment sheet on 2/8/2012 at 10:00 a.m. indicated a Low Air Loss Mattress. No instructions were noted on the treatment sheet indicating appropriate mattress settings for Resident # 8.</p> <p>On 2/9/2012 at 2:05 p.m., the DON located the IQ Low Air Loss Mattress instruction manual which advised the comfort setting should be set according to the individual patient's weight. This operation manual for the IQ Low Air Loss Mattress indicated a patient with the weight of 100-125 pounds should have a comfort setting of 4. The manual also indicated the mattress control unit features Instant In-Service, a built in audio component that provides users with immediate instructions on the proper use of the IQ Medical Mattress.</p> <p>Interview on 2/9/12 at 2:40 p.m., the DON indicated the hospice company had ordered the IQ Low Air Loss Mattress for Resident # 8. The DON also indicated the air mattress is now set on 4.</p> <p>3.1-40(a)(2)</p>						

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F0441 SS=F	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure linen was handled in a manner to prevent the spread of diseases/infections for 2 of</p>	F0441	F 441 I. The involved laundry aides were addressed and re-educated upon notification of improper handling of the soiled linen. II. As all residents could be	03/05/2012
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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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	<p>3 observations of linen handling. This had the potential to impact 70 of 70 residents residing in the facility. (Laundry aide #1)</p> <p>Findings include:</p> <p>On 2/07/12 at 1:40 a.m., Laundry aide #1 was observed passing personal linen down the 200 hallway. The laundry cart containing personal clothing was observed opened on 1 side as Laundry aide #1 was observed to enter 3 different rooms passing personal linen. She was also observed to remove a top from the cart and carry it next to her uniform as she entered a resident's room.</p> <p>On 2/7/12 at 2:45 p.m., Laundry aide #1 was observed pushing a barrel of personal laundry and cloth protectors down 1 hallway and then, turned into a second hallway to the laundry room door. At this same time during an interview, Laundry aide #1 indicated the barrel contained soiled linen. She also indicated linen should be covered during transportation.</p> <p>On 2/9/12 at 9:30 a.m. during the environmental tour during an interview, the Housekeeping Supervisor indicated laundry was done for all resident in the facility.</p>		<p>affected, nursing and laundry personnel have received inservice training in regard to the handling of clean and soiled linen in a manner to prevent the spread of infection. III. As a means to ensure ongoing compliance with handling linen in a manner to prevent spread of disease/infections, following inservice training, facility administrative staff will conduct observations at least 3 times weekly to confirm compliance. Should noncompliance be observed, immediate corrective action/re-education shall be initiated. IV. As a means of quality assurance, the results of the aforementioned observations as well as any interventions taken (if warranted) shall be reported to the Quality Assurance Committee on a quarterly basis. Addendum: Observations on handling of linens will include all three shifts.</p>				

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F0465 SS=B	<p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observations and interviews, the facility failed to ensure service areas were sanitary and in good repair related to the light coverings, ceiling gaps, and condition of the floors for 1 of 1 laundry room, for 2 of 6 storage/janitor closets, for 1 of 3 cleaned utility room, for 2 of 3 linen closets, for 1 of 1 nourishment pantry refrigerator, and for 1 of 1 medication supply room observed. This had the potential to impact 70 of 70 residents residing in the facility. (laundry room, nourishment pantry refrigerator, medication supply room, clean utility rooms near the nurse's station, 100 hall and 300 hall linen closet, 400 hall wheelchair closet, janitor closet)</p> <p>Findings include:</p> <p>1. On 2/9/12 at 9:30 a.m., the environmental tour was conducted with the Maintenance Supervisors and the Housekeeping Supervisor. The following was observed:</p> <p>(a) 100 hall In the clean linen closet - the floor was observed with paper clip, paper debri, and loose gray dust all over the floor with an accumulation of gray dust in the right corner of the entry</p>	F0465	<p>F465I. 1. A. The 100 Hall clean linen closet was thoroughly cleaned and the flooring was replaced. B. The medication supply room was thoroughly cleaned and ceiling repaired. The medication supply room was placed on a more frequent cleaning schedule. C. 400 Hall: The ceiling vent in the wheelchair storage closet was secured. The freezer of the refrigerator in the nourishment pantry was defrosted and placed on a schedule for routine cleaning and defrosting of the freezer. The janitor room ceiling light was secured to the ceiling. D. Laundry room: the floor was thoroughly cleaned. Floor tile will be repaired. The ceiling light cover has been cleaned and replaced.</p> <p>Necessary repairs will be made to the drywall. The flooring of the clean and soiled areas have been thoroughly cleaned and covers placed on fluorescent lights. The laundry room has been placed on a more frequent cleaning schedule. E. 300 Hall Linen Closet: the door threshold and floor has been thoroughly cleaned and the flooring was replaced. F. The clean utility room near the nurse's station: the light ceiling cover has been cleaned. II. As all residents could be affected, the following corrective actions have been taken. All cleaning</p>	03/05/2012			

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	<p>door to the closet. At this same time during an interview, the Housekeeping Supervisor indicated the common areas were to be cleaned/checked daily or at least cleaned weekly. He also indicated after buffing a floor, the buffer would throw debri under the doors.</p> <p>(b) In the medication supply room The floor was observed with loose dirt and debri throughout the supply room. One corner of the room around a shelf of supplies was observed with an accumulation of gray dust and debri. At this same time during an interview, the Housekeeping Supervisor indicated the room did need to be clean. Upon exiting the room, a quarter-sized hole and a nickel sized hole was observed in this same room's ceiling next to a set of pipes. The Maintenance Supervisor indicated the ceiling holes should be closed up.</p> <p>(c) 400 hall In the wheelchair storage closet, the ceiling vent cover was observed loosely hanging from the ceiling leaving an open gap visible;</p> <p>In the nourishment pantry, the freezer of the refrigerator was observed with a large accumulation of ice in the</p>		<p>schedules have been reviewed and updated to include schedule for cleaning of the common areas as well as storage closets, laundry rooms, etc. Housekeeping staff will receive inservice training in regard to increased frequency of cleaning schedules. III. As a means to ensure ongoing compliance with sanitary service areas, the housekeeping supervisor will be responsible to monitor adherence to the revised cleaning schedules through the conducting of weekly rounds throughout the facility to assess adequacy of the increased cleaning schedules. Should concerns with cleanliness and/or repair be noted, interventions shall be implemented immediately and cleaning schedules and/or systems re-evaluated and revised accordingly. IV. As a means of quality assurance, the aforementioned weekly rounds and any corrective actions taken (if warranted) shall be reported to the Quality Assurance Committee on quarterly basis.</p>				

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	<p>back and along the sides of this freezer. The Maintenance Supervisor indicated the freezer was used by the residents and needed to be defrosted.</p> <p>In the janitor room the ceiling light was observed on one side to have a open gap between the light and the ceiling.</p> <p>(d) Laundry room In the personal clothing area with personal clothing presently hanging, the floor was observed discolored with orange stained like areas scattered on the floor. Along the wall edges of this room, an accumulation of areas of light brown to gray areas were observed. One 12 inch floor tile in the middle corner of the room was observed with an irregular 1/8 inch missing portion of the tile missing. Loose dirt was observed inside this gap. The ceiling light cover was observed with a dried orange-like area with a large bug visible inside this cover. On the ceiling a cracked area of drywall was observed from the taped closed ceiling vent to the wall. In the designated clean and soiled areas of the laundry room, the floor was observed discolored with stained-like areas scattered throughout. The 6 fluorescent ceiling</p>						

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	<p>lights were observed without any covers on them.</p> <p>(e) 300 hall linen closet The door threshold was observed with an accumulation of loose dirt and debri in the area between the floor and the carpeted floor of the linen closet.</p> <p>(f) clean utility room located near the nurse's station The light ceiling cover was observed with an orange to light brown dried/stained light ceiling cover. At this same time during an interview, the Maintenance Supervisor indicated the orange-stained light covers found were probably not cleaned prior to putting them up.</p> <p>On 2/9/12 at 12:10 p.m., the Housekeeping Supervisor indicated he did not have a set schedule for the cleaning of the common areas. He indicated the common areas were to be checked by the staff during their room cleanings.</p> <p>3.1-19(f)</p>			
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