

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155143	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2012
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NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR NORTH RETIREMENT AND CONVALESCENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 3150 N SEVENTH ST TERRE HAUTE, IN 47804
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 27-31, and September 4, 2012</p> <p>Facility Number: 000067 Provider Number: 155143 AIM Number: 100267880</p> <p>Survey Team: Laura Brashear, RN, TC Mary Weyls, RN Teresa Buske, RN Deb Skinner, RN</p> <p>Census bed type: SNF/NF: 68 Total: 68</p> <p>Census payor type: Medicare: 5 Medicaid: 51 Other: 12 Total: 68</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 7, 2012 by Bev Faulkner,</p>	F0000	<p>Please consider this Plan of Correction as our allegation of compliance. <u>Disclaimer:</u> _Meadows Manor North Retirement and Convalescent Center, Inc. (Meadows) does not believe and does not admit that any deficiencies existed before, during or after survey. Meadows reserve all rights to contest proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Meadows reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potential applicable peer review, quality assurance or self critical examination privileges which Meadows does not waive and reserves the right to assert in any administrative civil or criminal claim, action or proceeding. Meadows offers its response, credible allegation of compliance allegation of compliance and plan of correction as part of its ongoing effort to provide quality of care.</p>	

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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F0223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to prevent mental abuse for 1 of 2 investigations of allegations against staff members reviewed. This affected Resident #5.</p> <p>Finding includes:</p> <p>On 8/31/12 at 1:40 p.m., a report of an investigation, provided by the Administrator of an allegation against a staff member was reviewed. The investigational report, dated 7/3/12, documented CNA #23 was transferring Resident #5 from a shower chair to bedside commode. CNA #23 asked CNA #24 for assistance with the transfer. CNA #23 indicated CNA #24 was being very rushed putting the safety strap for the stand up lift on the resident. The resident asked for the staff member to wait a minute and CNA #24 responded she did not have a minute. CNA #23 requested CNA #24 leave and she would get</p>	F0223	<p>On July 3, 2012 an allegation of abuse was made against CNA #24. Nursing staff followed facility policy and procedure by immediately protecting the resident and suspending the CNA . Administrator and Director of Nursing were notified of the incident. July 4, 2012 he DON interviewed all parties involved in the incident. All residents on the unit were interviewed no other concerns were noted. CNA #24 was trained on resident's rights upon hire and attended resident right inservices while employed. Upon review on the investigation, by the administrator, CNA #24 was terminated for causing emotional distress to a resident by her actions. The Staff followed the facility protocol therefore there was no potential for harm to any other resident. The Quality Assurance committee reviews all allegation of abuse at the quarterly meeting.</p>	09/04/2012	

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	<p>assistance from another staff member.</p> <p>On 7/4/12, the DON interviewed the resident. The resident indicated CNA #24 was rude and in a hurry. The resident's roommate was interviewed and she indicated the CNA had a bad attitude upon entering the room at approximately 10:00 p.m.</p> <p>A written report from LPN #25, dated 7/3/12, included, but not limited to, "CNA #24 came across the hall to room she was working in frustrated, red, stating 'I just can't do this anymore, I just can't take it.'" LPN #25 went to console the resident who felt like she was not being treated right. The LPN documented she sat for a while listening to the resident vent and resident stated she felt a little better.</p> <p>A written statement provided by CNA #23, dated 7/3/12, included, but was not limited to, "I was transferring [resident's name] from shower chair to bedside commode and I asked [CNA name] #24 for help to transfer her. She came into the room being hateful and huffy and ruff [sic] with [resident's name] #5 throwing the Sara lift strap around [resident's name] #5 and [resident's name] #5</p>						

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	<p>asked [CNA's name] to slow down because she can't go that fast and [CNA name] told her she did not have the "f----g" time to slow down and [resident's name] asked her to stop and I told her to go and I would get [CNA name] [another CNA on duty] to help me with [resident's name] and CNA's name [CNA #24] said " fine "f--k" this" and stormed out of the room ranting and huffing. And left her [the resident's] right arm up in the strap."</p> <p>The Administrator was interviewed on 8/31/12 at 1:30 p.m. The Administrator indicated the resident indicated she felt like she had done something to make the CNA mad and LPN #25 had gone to the resident to help calm her down. The Administrator indicated after completion of the investigation it was determined the resident had emotional harm and CNA #24 was terminated.</p> <p>The investigative documentation included steps followed after the allegation and no concerns were identified.</p> <p>The facility's policy titled "Reporting Abuse to Facility Management," no date, provided by the Administrator on 8/31/12 at 2:30 p.m. included, but</p>			

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	<p>was not limited to, "1. Our facility will not condone resident abuse by anyone, including staff members, ...7. a. Abuse is defined as the willful infliction of injury; unreasonable confinement: intimidation; punishment with resulting physical harm, pain, or mental anguish or deprivation by an individual including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. b. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance. ..." f. Mental abuse is defined as, but not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services."</p> <p>3.1-27(b)</p>			

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F0252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>Based on observation and interview, the facility failed to ensure a homelike room for 1 of 40 resident rooms observed in that a vacant bed in double room remained unmade throughout the survey. This affected Resident #114.</p> <p>Finding includes:</p> <p>On 8/27/12 at 1:20 a.m., Resident #114 was interviewed and her room was observed. The resident's room was a double room, with no roommate. A low air loss bed was observed in the room, deflated and unmade. A blue recliner was observed positioned between the two beds in the room and noted to have dark stains on the head rest. Resident #114 indicated she did not utilize the chair and felt like she was in a storage room.</p> <p>The unmade bed and blue stained chair were observed daily from 8/27/12 -8/31/12. On 9/4/12 at 1:00 p.m., a regular bed was observed in place of the air loss bed, but was</p>	F0252	<p>It is the policy of the facility to provide a homelike environment. Resident # 114 did not state she wanted the lounge chair removed from her room. She had occasionally utilized the lounge chair since her admission. On 9/11/12 the chair was removed from resident's room. The unoccupied bed was made on 9/4/12.</p> <p>Nursing staff and housekeeping staff were reminded that all unoccupied beds needs to be made.</p> <p style="text-align: center;">Completed</p> <p>9/20/12</p> <p>Unit Mangers will inspect the hall at least 3 times per week for the next 4 weeks and then randomly thereafter to verify that all unoccupied beds are made. (see Homelike checklist) If any unoccupied beds are not properly made unit manager will address the concern with the floor and staff and ensure beds are made. Unit managers will inform DON/Administrator of any concerns identified. The quality assurance committee will review any identified concerns for the next 6 months.</p>	09/14/2012			

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	noted not to be made. 3.1-19(f)(5)			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation and record review, the facility failed to ensure each resident received personal hygiene after incontinence for 1 of 2 residents observed during incontinent care. (Resident #16).</p> <p>Findings include:</p> <p>1. On 8/30/12 at 12:28 p.m., Resident #16 was observed to be toileted by CNA #20. The resident was observed to be incontinent of urine. The resident's disposable pad was urine saturated and the resident's pants were observed to be changed as well. The CNA was observed to utilize toilet paper only to wipe the resident skin after being toileted. Incontinence care was not completed for the resident.</p> <p>Upon review of Resident #16's clinical record on 8/31/12 at 12 p.m., the most recent Minimum Data Set (MDS) was noted completed 7/24/12. The assessment identified the resident with extensive assistance</p>	F0312	<p>It is the policy of the facility that all residents receive personal hygiene after being incontinent. Resident #16 had a urinary tract infection prior to the alleged incident with CNA #20. All CNA's were reinserviced regarding proper perineal care performed a skill check off.</p> <p>Unit managers will observe at least 5 incontinence care per week for the next 4 weeks, then at least 3 per week for the next 2 months, and randomly thereafter. Any staff member not performing proper care will be immediately reinserviced. Unit manager will inform DON/Administrator of any concerns identified. (See attached monitoring tool) The DON/Administrator will share the unit manager concerns with the Quality Assurance quarterly for the next 12 months.</p>	09/20/2012			

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	<p>required for transfers, toilet use and personal hygiene.</p> <p>The resident's current care plan identified the problem of self care deficit related to decreased mobility, osteoporosis, anxiety, depression, and use of psychotropic medications dated 4/1/11 and updated 8/12. The approaches included but were not limited to assist or provide activities of daily living/personal care prn, and provide incontinent care prn.</p> <p>Documentation in nursing notes, dated 9/3/12 at 3:20 a.m., indicated antibiotic continued for urinary tract infection.</p> <p>3.1-38(a)(3)(A)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a safe environment for 1 of 15 residents identified utilizing siderails, in that Resident #19's siderails were observed loose and leaning away from the mattress.</p> <p>Finding includes:</p> <p>On 8/29/12 at 11:23 a.m. , a 1/2 siderail was observed in the up position, on the right side of Resident #19's bed. The siderail was observed to lean outward, away from the mattress.</p> <p>During the general tour on 9/4/12 at 11 a.m., with the Maintenance Staff #22, Resident #19's bed was observed with two siderails. The siderails were leaning out away from the mattress. The maintenance staff pulled and pushed on the siderails and indicated the rails were very loose. The maintenance staff tightened the siderails.</p>	F0323	Residents #19 side rails were still attached to the bed frame and working properly. Maintenance tightened the siderails prior to leaving the room. To ensure further compliance Maintenance will perform weekly siderail inspection for the next 4 weeks and then monthly thereafter to ensure all side rails are properly tightened to the bed frame. (See attached monitoring tool) The maintenance supervisor will review log and report any concern to the Administrator. The Quality Assurance committee will review all safety concerns at the quarterly meeting for the next 12 months.	09/14/2012	

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	<p>Resident #19's clinical record was reviewed on 9/4/12 at 2 p.m.</p> <p>A siderail assessment, dated 8/24/12, indicated the resident expressed a desire to have side rails while in bed to assist in moving about in bed, and at times expressed a desire to have the left side rail down.</p> <p>The assessment also indicated the resident had poor balance and trunk control at times and attempted at times to get out of bed without assistance.</p> <p>A quarterly Minimum Data Set [MDS] assessment, dated 6/1/12, indicated the resident required assistance of one person for bed mobility and transfers.</p> <p>3.1-45(a)(1)</p>				

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F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure each resident room was maintained in a sanitary condition for 1 of 40 resident rooms observed in that urine odor was noted on 6 of 6 days of survey. [Resident room #91].</p> <p>Findings include:</p> <p>1. On 8/27/12 at 2 p.m., Resident #91's room was noted to have a strong urine odor.</p> <p>On 8/28/12 at 10 a.m., a urine odor was noted in Resident #91's room.</p> <p>On 8/29/12 at 10:40 a.m., Resident #91 was observed to be present in her room seated in a personal recliner. A strong urine odor was present. On 8/29/12 at 11:50 a.m., Resident #91 was observed not to be in the room and a strong urine odor remained in the room.</p> <p>On 8/30/12 at 11:09 a.m., a strong urine odor was noted to be present in Resident #91's room.</p>	F0465	<p>It is the policy of the facility to maintain a sanitary condition. Resident #91 sits in her recliner and routinely refuses personal care. Housekeeping and nursing clean and disinfect the chair on a daily basis. The son had replaced the chair 5 months ago due to the odor. On 9/5 & 9/6/12 housekeeping attempted once again to remove the odor from to the chair, and was unsuccessful. A meeting was held with the son on 9/7/12 and he choose to remove the chair and not replace it. The head of housekeeping will perform weekly inspections for any unsanitary condition for the next 4 weeks and then monthly thereafter for the next 6 months to ensure compliance. (See attached monitoring too) Housekeeping will report any concerns to the Administrator. The Administrator will review all concerns and meet with residents families if the concern is regarding residents' personal property. All concerns will be reviewed in Quality Assurance meeting for the next 12 months.</p>	09/14/2012

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	<p>On 8/31/12 at 8:30 a.m., a strong urine odor was noted in Resident #91's room.</p> <p>On 9/4/12 at 1:10 p.m., a strong urine odor was noted in Resident #91's room.</p> <p>Upon interview of Housekeeper #21 on 9/4/12 at 1:15 p.m., the Housekeeper indicated Resident #91 was incontinent of urine at times in her recliner. The housekeeper indicated the room, the recliner, and the area under the recliner were cleaned daily. The housekeeper also stated that the staff utilizes disinfectant and deodorizer on the recliner, but that an odor remains in the recliner. The housekeeper indicated a strong urine odor has been noted in the room.</p> <p>Upon interview of CNA #20 on 9/4/12 at 1:20 p.m., the CNA indicated Resident #91 was incontinent of urine while in the recliner at times. The CNA stated the resident was not aware of the need to go to the bathroom all of the time. The CNA also indicated if housekeeping was not available to cleanse the recliner they cleansed the recliner with disinfectant.</p>			

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	<p>Upon interview of the Administrator on 9/4/12 at 4:50 p.m., the Administrator indicated the family had replaced Resident #91's recliner previously.</p> <p>3.1-19(f)</p>			