

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 29, 30, 31, February 1, 4, 2013</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Survey team: Karen Lewis, RN, TC Betty Retherford, RN Ginger McNamee, RN Toni Maley, BSW</p> <p>Census bed type: SNF: 19 SNF/NF: 52 Total: 71</p> <p>Census payor type: Medicare: 12 Medicaid: 53 Other: 6 Total: 71</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p>	F0000		

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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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 of high and/or low blood sugar readings in accordance with physician's orders</p>	F0157	<p>1. Resident #51 and Resident #90 incurred no negative outcome. Resident #51 and Resident #90 physicians have been notified of their blood glucose monitoring results. 2. All</p>	02/25/2013			

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	<p>for 2 of 5 residents reviewed with orders for diabetic monitoring. (Resident #'s 51 and 90)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #51 was reviewed on 1/31/13 at 10:35 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, diabetes mellitus, diabetic neuropathy, and obsessive compulsive disorder.</p> <p>A recapitulation of physician orders, dated 1/15/13, indicated resident #51 had diabetic related orders which included, but were not limited to, the following:</p> <p>Insta-Glucose 40% gel (a medication given to raise the blood sugar levels) - give 31 grams by mouth as needed for blood sugar below 60 and resident conscious.</p> <p>Humulin 70/30 insulin-give 34 units subcutaneously bid (two times daily)</p> <p>Lantus insulin-10 units subcutaneously daily</p> <p>Call MD (medical doctor) for BS (blood sugar) below 60 or above 400</p>		<p>residents who have ordered blood glucose level monitoring have the potential to be affected. All residents who have ordered blood glucose level monitoring were reviewed to ensure physicians are being notified as per ordered parameters. 3. The facility's policy and procedure for blood glucose monitoring has been reviewed and no changes were made. (Attachment 1) The nurses have been re-educated on the policy and procedure. (Attachments 2-A-B-C-D-E) 4. The DON or her designee will monitor all residents who receive blood glucose monitoring on scheduled days of work daily for one month, two times weekly for one month, then weekly thereafter until compliance is maintained for a minimum of 6 months. (Attachment 3) Should concerns be observed, re-education will be provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>		

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	<p>Accucheck before meals and at bedtime (no sliding scale insulin ordered for this resident)</p> <p>The "Blood Glucose Monitoring Records" for December 2012 and January 2013 indicated accuchecks were to be completed at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m. The records indicated the following:</p> <p>12/27/12 at 6:30 a.m.-The resident's blood sugar was recorded as 53.</p> <p>1/6/13 at 6:30 a.m. The resident's blood sugar was recorded as 39.</p> <p>1/6/13 at 11:30 a.m. The resident's blood sugar was recorded as 55.</p> <p>1/11/13 at 6:30 a.m. The resident's blood sugar was recorded as 55/51. [taken twice]</p> <p>1/12/13 at 6:30 a.m. The resident's blood sugar was recorded as 39.</p> <p>1/13/13 at 9:00 p.m. The resident's blood sugar was recorded as 405.</p> <p>1/14/13 at 9:00 p.m. The resident's blood sugar was recorded as 429.</p> <p>The Blood Glucose Monitoring</p>			

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	<p>Records and nursing notes lacked any notification of the physician and/or assessment of the resident related to the low and high blood sugar readings for the dates and times noted above.</p> <p>During an interview with the DoN and RN consultant on 2/4/13 at 11 a.m., additional information was requested related to the lack of physician notification of the low and high blood sugar readings noted above in accordance with the physician's orders.</p> <p>During an interview on 2/4/13 at 4:50 p.m., the RN consultant indicated the facility had no additional information to provide related to physician notification of the low and high blood sugar readings noted above.</p> <p>2.) The clinical record for Resident #90 was reviewed on 2/1/13 at 1 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic renal failure, end stage renal disease, diabetes mellitus type 2, history of non compliance, and bipolar disorder.</p> <p>A recapitulation of physician orders, dated 12/30/12, indicated resident #90 had diabetic related orders which</p>			

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	<p>included, but were not limited to, the following:</p> <p>Accucheck before meals and at bedtime. (original order date 4/27/12)</p> <p>Call MD (medical doctor) for BS (blood sugar) below 60 or above 400 (original order date 7/12/12)</p> <p>The "Blood Glucose Monitoring Records" for December 2012 indicated accuchecks were to be completed at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m.</p> <p>The records indicated the following:</p> <p>12/7/12 at 4:30 p.m.-The resident's blood sugar was recorded as 409. The clinical record lacked any information related to physician notification of the blood sugar reading above 400.</p> <p>During an interview with the DoN and RN consultant on 2/4/13 at 11 a.m., additional information was requested related to the lack of physician notification of high blood sugar reading on 12/7/12 at 4:30 p.m. in accordance with the physician's orders.</p> <p>During an interview on 2/4/13 at 4:50</p>			

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	<p>p.m., the RN consultant indicated the facility had no additional information to provide related to physician notification of the high blood sugar reading noted above.</p> <p>3.) The undated "Physician & Family Notification Procedure" was provided by the RN Consultant at 3:44 p.m. on 2/4/13. The procedure indicated: "Purpose: To keep the physician, resident, and family appraised [sic] of all condition changes. Procedure: Telephone: 1. Telephone notification is required for all emergencies or all changes that require immediate results. 2. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan.... 4. Document the information reported to the physician in the nurses notes including the time and date of notification. Be thorough and explicit...."</p> <p>3.1-5(a)(2)</p>				

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F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure resident dignity was maintained by posting care issues on signs visible to the public for 5 of 9 resident's reviewed for dignity. (Residents #7, #54, #20, #55 and #12).</p> <p>Findings include:</p> <p>During observations on the following dates and times resident respiratory care information was posted prominently in resident rooms:</p> <p>a.) On 1/29/13 at 3:05 p.m., Resident #12 had a sign posted above the oxygen tank in her room. The sign indicated "Please turn oxygen equipment off while not in use. This resident is on 2L [2 liters]." Resident #12 was seated in a wheelchair in her room at this time.</p> <p>b.) On 1/29/13 at 3:10 p.m., Resident #20 had a sign posted above the oxygen tank in her room. The sign indicated "Please turn oxygen</p>	F0241	<p>1) The signs have been removed from resident # 37, #54, #20, #55 and # 12 rooms. 2) All residents have the potential to be affected. An audit of all resident rooms has been conducted to ensure no care issues are posted in resident rooms. 3) Facility staff has been re-educated in regards to Resident Rights and prohibition of signage relative to resident care. (Attachment 2-A-B-C-D-E-F)</p> <p>4) The DON or her designee will conduct rounds on scheduled days of work on a daily basis for one month, two times weekly for one month, then weekly thereafter until compliance is maintained for 6 months. (Attachment 4) Should non-compliance be observed, corrective action will be taken. The results of these rounds will be reviewed at the quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>	02/25/2013			

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	<p>equipment off while not in use. This resident is on 2L [2 liters]." Resident #20 was seated in a chair in her room at this time.</p> <p>c.) On 1/31/13 at 2:15 p.m., Resident #55 had a sign in his room above the head of his bed. The sign indicated "O2 [oxygen] is PRN [as needed] humidity is continuous while in bed." Resident #55 was in his bed at this time.</p> <p>d.) On 1/31/12 at 2:17 p.m., Resident #7 had a sign posted above the oxygen tank in her room. The sign indicated "Please turn oxygen equipment off while not in use. This resident is on 3L [liters]." Resident #7 was seated in a chair in her room at this time.</p> <p>e.) On 1/31/12 at 2:19 p.m., Resident #54 had a sign posted above the bedside table in her room. The sign had a long list of multiple instructions regarding respiratory care and treatment. Resident #54 was asleep in her bed at this time.</p> <p>During a 1/31/13, 2:30 p.m. interview, the administrator indicated he believed the contracted respiratory therapy department had posted the signs and he would look into the</p>			

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	<p>matter.</p> <p>During a 1/31/13, 3:00 p.m., interview, the Director of Nursing indicated the respiratory information was no longer visibly posted in resident rooms.</p> <p>3.1-3(m) 3.1-3(t)</p>			

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident, who received multiple psychoactive medications, had identified targeted behaviors being treated by psychoactive medication and documented behaviors when psychoactive medications were used, and a resident who had physician's orders for a psychological evaluation had arrangements made for the evaluation for 2 of 2 residents reviewed for medically needed social services. (Resident #74 and #53)</p> <p>Findings include:</p> <p>1.) Resident #74's clinical record was reviewed on 2/4/13 at 3:00 p.m.</p> <p>Resident #74's current diagnoses included, but were not limited to, anxiety, Alzheimer's disease and post cerebral vascular accident (stroke).</p> <p>Resident #74 had current 2/13 physician's orders for the following as needed psychoactive medications:</p>	F0250	<p>1. The current medication orders for Resident #74 and #53 have been reviewed and clarified to ensure that all ordered PRN psychoactive medications have identified target behaviors. Resident # 53 has had a psychiatric consult. 2. All residents who have ordered PRN psychoactive medications have the potential to be affected. All residents who have orders for PRN psychoactive medications clinical records have been reviewed to ensure that they each have identified target behaviors as a rational for the use of PRN psychoactive medication. The clinical record was also reviewed to ensure that behaviors, warranting the use of said medications, have been correctly documented (i.e. behavior memos). All resident clinical records were reviewed to ensure that all psychiatric consult recommendations were followed thru. 3. The policy and procedure related to PRN psychoactive medications has been reviewed and no changes were made. (See attachments 5-A-B-C-D-E-F-G-H-I) The nurses were re-educated on the policy and procedure in</p>	02/25/2013

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	<p>a.) Zoloft (antidepressant) 100 mg - 1 tablet 1 time daily, give with 25 mg to total 125 mg. This order originated 1/14/13.</p> <p>b.) Zoloft 25 mg - 1 tablet 1 time daily, give with 100 mg to total 125 mg. This order originated 1/14/13.</p> <p>c.) Seroquel (anti-psychotic) 25 mg - 1 tablets 2 times daily. This order originated 1/14/13.</p> <p>d.) Zyprexa (anti-psychotic) 2.5 mg - 1 tablet 2 times daily. This order originated 1/23/13.</p> <p>e.) Haloperidol Lac (Haldol-anti-psychotic) 5 mg/ml vial-inject 1 ML (5 mg) every 8 hours as needed (no criteria for use). This order originated 1/23/13.</p> <p>f.) Ativan (anti-anxiety) 1 mg - 1 mg give 1 tablet as needed every 4 hours (no criteria for use). This order originated 1/14/13.</p> <p>g.) Zyprexa (anti-psychotic) 2.5 mg - 1 tablet as needed every 6 hours (no criteria for use). This order originated 1/23/13.</p> <p>Review of Resident #74's "PRN [as</p>		<p>regards to administration of PRN psychoactive medications. (See attachments 2-A-B-C-D-E) 4. The DON or her designee will monitor the administration of PRN psychoactive medications to ensure the appropriate documentation to support PRN administration is in place daily on scheduled days of work daily for one month, two times weekly for one month, then weekly thereafter until compliance is maintained for 6 months. (See attachment 6) Should non-compliance be noted, immediate corrective action shall be taken. The results of these observations will be discussed in the quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>	

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	<p>needed] Medication Flow Sheet" for January and February (2/1/13 to 2/4/13) 2013 indicated the resident received 14 doses of as need psychoactive medications during this period. Of the 14 doses, 8 lacked documentation of a description of the behavioral event and documentation if any non-chemical interventions had been attempted prior to the administration of the medications. The 8 events were as follows:</p> <p>a.) 1/2/13, 12:05 a.m.-Ativan 1 mg given for "anxiety." b.) 1/4/13, 7:30 a.m.-Ativan 1 mg given for "anxiety." c.) 1/22/13, 10:00 a.m.-Haldol 5 mg given for "agitation." d.) 1/29/13, 4:45 (a.m. or p.m. not indicated)- Haldol 5 mg given- no other documentation. e.) 1/29/13, 4:15 (a.m. or p.m. not indicated)- Ativan 1 mg given for "agitation." f.) 1/13/13, 2:40 p.m.-Haldol 5 mg given for "agitation." g.) 1/31/13, 3:05 p.m.-Ativan 1 mg given for "agitation." h.) 2/1/13, 6:00 p.m.-Haldol 5 mg given for "agitation."</p> <p>During a 2/4/13, 4:00 p.m. interview, the Social Service Designee indicated he had no other behavioral documentation to provide regarding</p>						

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	<p>the 8 doses of as needed medication.</p> <p>The clinical record lacked documentation of any identified, specific, targeted behaviors being treated by the anti-anxiety and anti-psychotic medications. The "Behavior Monthly Flow Record" for December 2012, January 2013, and February 2013 did not contain specific behaviors for tracking and had broad behavioral symptoms as follows: signs and symptoms of anxiety, socially inappropriate behaviors, and wandering exit seeking.</p> <p>During an 2/4/13, 4:50 p.m. interview, the Social Service Consultant indicated the facility did not identify specific target behaviors and tracked general behaviors on the flow records. He additionally indicated when an behavioral event occurred the "Mood and Behavior Communication Memo" should be completed, but none had been completed. When queried if a behavior memo should have accompanied all the as needed psychoactive medication used, he indicated yes.</p> <p>2.) The clinical record for Resident #53 was reviewed on 2/4/13 at 9:03 a.m.</p>						

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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	<p>Diagnoses for Resident #53 included, but were not limited to, dementia with behaviors, anxiety, and paranoid ideations.</p> <p>Resident #53 had current physician's orders for the following,</p> <p>a.) Ativan (an anxiety medication) 0.5 mg 1 tablet by mouth 2 times a day. The original date of this order was 12/3/11.</p> <p>b.) Seroquel (an antipsychotic medication) 100 mg 1 tablet by mouth 2 times a day. The original date of this order was 12/3/11.</p> <p>A "Gradual Dose Reduction Form," dated 1/4/13, indicated the physician agreed with the pharmacy consultant's recommendations and also ordered a psych (psychological) consultation for the resident.</p> <p>The clinical record lacked any information related to a referral for psychological services having been made related to the physician's order.</p> <p>During an interview with the DoN (Director of Nursing), RN Consultant, and Administrator on 2/4/13 at 10:54 a.m., additional information was</p>			

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 02/04/2013
NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012		
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	<p>requested related to the lack of referral for a psychological consult for Resident #53.</p> <p>During an interview on 2/4/13 at 12:35 p.m., the Social Services Designee indicated no referral for care had been made prior to the request for information on 2/4/13.</p> <p>Review of the current policy, dated 9/2005, titled "PHYSICIAN'S ORDERS PROCEDURE," provided by the RN consultant on 2/4/13 at 4:55 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure accurate and complete physician's orders....</p> <p>...PROCEDURE:...</p> <p>...5. Transcribe new order on MAR or TAR as indicated. Follow order through to completion-make appointments, order labs, notify pharmacy, etc...."</p> <p>3.1-34(a)</p>				

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 02/04/2013	
NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES				STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012			
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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the nursing staff failed to ensure a laboratory test was obtained timely as ordered by the nurse practitioner for 1 of 34 residents reviewed for following physician orders. (Resident #53)</p> <p>Findings include:</p> <p>Clinical record for Resident #53 was reviewed on 2/4/13 at 9:03 a.m.</p> <p>Diagnoses for Resident #53 included, but were not limited to, diabetes mellitus, hypertension, anemia, and edema.</p> <p>A "Nursing Home Progress Note," dated and signed by the nurse practitioner on 1/16/13, indicated Resident #53 was to have a Thyroid Stimulating Hormone (TSH) laboratory test "now and then yearly".</p> <p>The clinical record lacked any results for a TSH laboratory test, ordered by the physician on 1/16/13, for Resident #53.</p>	F0282	<p>1) The lab for Resident # 53 was obtained. Resident #53 incurred no negative outcome. 2) All residents have the potential to be affected. All resident clinical records were reviewed to ensure that labs were obtained as ordered. 3) The facility's policy and procedure for transcription of physician orders has been reviewed and no changes were made. (See attachment 7) The nurses were re-educated on the policy and procedure in regards to transcription of physician orders. (See attachment 2-A-B-C-D-E) 4) The DON or her designee will monitor all lab orders on scheduled days of work daily for one month, two times weekly for one month, then weekly thereafter until compliance is maintained for a minimum of 6 months. (See attachment 8) Should non-compliance be observed, corrective action will be taken. The results of these observations will be discussed in the quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>	02/25/2013			

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 02/04/2013	
NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES				STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>During an interview with the DoN (Director of Nursing), RN Consultant, and Administrator on 2/4/13 at 10:54 a.m., additional information was requested related to the lack of a January TSH laboratory result for Resident #53.</p> <p>During an interview with the RN consultant on 2/4/13 at 4:50 p.m., she indicated she had no other information to provide related to the missing TSH laboratory test for Resident #53.</p> <p>Review of the current policy, dated 9/2005, titled "PHYSICIAN'S ORDERS PROCEDURE," provided by the RN consultant on 2/4/13 at 4:55 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure accurate and complete physician's orders....</p> <p>...PROCEDURE:...</p> <p>...5. Transcribe new order on MAR or TAR as indicated. Follow order through to completion-make appointments, order labs, notify pharmacy, etc...."</p> <p>3.1-35(g)(2)</p>						

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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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 02/04/2013
NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012		
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F0309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>A.) Based on record review and interview, the facility failed to ensure necessary fluid restrictions and dialysis monitoring were completed in accordance with the resident's plan of care for 2 of 2 residents reviewed who received dialysis services. (Resident #'s 90 and 33)</p> <p>B.) Based on record review and interview, the facility failed to complete accuchecks as ordered, administer insulin as ordered, and notify the physician as ordered for 3 of 5 residents reviewed for diabetic monitoring and insulin administration. (Resident #'s 51, 55, and 90)</p> <p>Findings include:</p> <p>A1.) The clinical record for Resident #33 was reviewed on 1/31/13 at 4:50 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic renal failure, acute onset aggressive</p>	F0309	<p>1. Residents # 33, # 90, #51 and #55 incurred no negative outcome. Residents # 90 and #33 have the necessary fluid restrictions in place and are being monitored in accordance with their plan of care related to dialysis. Residents #51, #55 and #90 are receiving accuchecks as ordered, insulin has been administered per physicians order and the physician has been notified of blood glucose results per ordered parameters. 2. All resident who receive dialysis were reviewed to ensure fluid restrictions are in place, if ordered, and they are being monitored in accordance with their plans of care related to dialysis. All residents who have ordered accuchecks or orders for insulin administration have been reviewed to ensure that accuchecks are completed as ordered, insulin is administered as ordered and the physician is notified per ordered parameters. 3. The facility policy and procedure for fluid restriction has been reviewed and no changes were made. (See</p>	02/25/2013	

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 02/04/2013
NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>behavior, Alzheimer's dementia, and hypertension.</p> <p>A current health care plan problem, dated 3/12/12, and last reviewed on 1/23/13, indicated the resident had end stage renal disease and received hemodialysis treatments with the potential for complications associated with hemodialysis. Interventions for this problem included, but were not limited to, the following:</p> <p>"Observe the site for redness, drainage, or other signs of infection.</p> <p>Monitor shunt for bruit and thrill daily. Advise the physician if absent.</p> <p>Monitor shunt site after return from dialysis treatment.</p> <p>Encourage resident to follow all dietary and fluid restrictions.</p> <p>Monitor intake and output every shift."</p> <p>Current physician's orders, dated 1/16/13, indicated the resident was to have dialysis treatments on Tuesdays, Thursdays, and Saturdays. The original date of this order was 6/20/11. The resident also had additional dialysis related orders which included, but were not limited</p>		<p>attachment 9)The facility policy and procedure for dialysis residents has been reviewed and no changes were made (See attachment 10-A-B). The facility's policy and procedure for blood glucose monitoring has been reviewed and no changes were made. (See attachment 1)The policy and procedure for insulin injections has been reviewed and no changes were made. (See attachment 11-A-B) The nurses have been re-educated on the above policies and procedures. (See attachment 2-A-B-C-D-E)</p> <p>4. The DON or her designee will monitor all residents who receive dialysis to ensure the communication form is being completed by the facility and dialysis unit, post dialysis assessments are completed, fluid restrictions are tallied and care plans are in place in regard to fluid restrictions on scheduled days of work three times a week after dialysis for three months and then one time weekly thereafter until compliance is maintained for a minimum of 6 months. (See attachment 12) Should concerns be observed, re-education will be provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted. The DON or her designee will monitor all residents who receive blood glucose monitoring and insulin</p>		

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to, the following: 1500 milliliters (ml) fluid restriction daily and dialysis assessment every shift on dialysis days.</p> <p>This indicated the resident should have had 27 dialysis treatments during the months of December 2012 and January 2013.</p> <p>The order for the dialysis assessment every shift was present on the physician's orders, but was not listed on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) for the months of December 2012 and January 2013.</p> <p>The clinical record contained one post dialysis assessment following dialysis treatments on December 1, 8, 15, 18, 22, 24, and 31, 2012 and January 3, 5, 8, 15, 2013. The nursing notes for December 2012 and January 2013 contained only one dialysis related assessment for Resident #33, which was dated 1/15/13 (no time given) and pertained to the resident's return from dialysis.</p> <p>The clinical record lacked any other shift or daily dialysis related assessments for the resident. This indicated only 11 dialysis related</p>		<p>injections to ensure that documentation is completed, physician was notified as set forth by the ordered parameters, and the correct insulin dosage was administered on scheduled days of work daily for one month, two times weekly for one month then weekly thereafter until compliance is maintained for a minimum of 6 months. (See attachment 3) Should concerns be observed, re-education will be provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>	

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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	<p>assessments had been completed in a 61 day time period.</p> <p>The clinical record lacked any communication sent from the dialysis provider to the facility following the dialysis treatments for the months of December 2012 and January 2013.</p> <p>During an interview on 2/1/13 at 10:15 a.m., RN #1 (the nurse providing care to Resident #33) indicated the facility did not receive any post dialysis information from the dialysis provider following treatments. She indicated the nursing staff are to complete an assessment following the resident's return and identified the form used for assessment.</p> <p>A quarterly dietary progress note, dated 1/18/13, indicated the resident had a 1500 ml daily fluid restriction. The current Fluid Distribution Sheet indicated the resident was to receive 1000 ml of fluid from the dietary department daily and 500 ml fluid from the nursing department daily. The division was as follows: breakfast 360 ml, lunch 360 ml, dinner 240 ml, and bedtime snack 40 ml from the dietary department. The nursing division was allowed 200 ml on the day shift, 150 ml on the evening shift, and 150 ml on the midnight shift.</p>			

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The clinical record contained food consumption records which monitored the resident's fluid intake with each meal, but did not record the amount of fluid consumed with the bedtime snack.</p> <p>The clinical record lacked any documentation of how much fluid the resident consumed from the nursing staff during each shift or any 24 hour fluid intake totals. The clinical record lacked any method to monitor the 24 hour fluid restrictions ordered by the physician.</p> <p>During an interview with the DoN and RN consultant on 2/4/13 at 11 a.m., additional information was requested related to the lack of communication with the dialysis provider following treatments, the lack of assessment and monitoring of resident following dialysis treatments and in accordance with the resident's plan of care, and the lack of 24 hour fluid restriction monitoring.</p> <p>During an interview on 2/4/13 at 4:50 p.m., the RN consultant indicated the facility had no additional information to provide related to these concerns.</p> <p>A2.) The clinical record for Resident</p>			

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#90 was reviewed on 2/1/13 at 1 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic renal failure, end stage renal disease, diabetes mellitus type 2, history of non compliance, and bipolar disorder.</p> <p>A current health care plan problem, dated 10/22/12, and last reviewed on 1/20/13, indicated the resident had end stage renal disease and received hemodialysis treatments with the potential for complications associated with hemodialysis. Interventions for this problem included, but were not limited to, the following:</p> <p>"Observe the site for redness, drainage, or other signs of infection.</p> <p>Monitor shunt for bruit and thrill daily. Advise the physician if absent.</p> <p>Monitor shunt site after return from dialysis treatment.</p> <p>Encourage resident to follow all dietary and fluid restrictions.</p> <p>Monitor intake and output every shift."</p> <p>The clinical record indicated the resident was scheduled for dialysis treatments on Tuesdays, Thursdays,</p>			

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and Saturdays related to end stage renal disease. The resident also had a physician's order, dated 12/30/12, for a 1500 ml fluid restriction daily. The original date of this order was 5/3/12.</p> <p>This indicated the resident should have had 27 dialysis treatments during the months of December 2012 and January 2013.</p> <p>The clinical record contained one post dialysis assessment following dialysis treatments on December 11 and 15, 2012 and January 17, 26, 29, and 31, 2013.</p> <p>The clinical record indicated the resident refused dialysis treatments on December 1, 4, 8, 18, 22, 2012 and 1/3, 19, 2013. The clinical record lacked any information related to the doctor being notified of the resident's dialysis refusals.</p> <p>The nursing notes for December 2012 and January 2013 lacked any other dialysis related assessments for Resident #90.</p> <p>The clinical record lacked any other dialysis related assessments for the resident. This indicated only 6 dialysis related assessments had been completed in a 61 day time</p>			

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 02/04/2013	
NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES				STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>period.</p> <p>The clinical record lacked any communication sent from the dialysis provider to the facility following the dialysis treatments for the month of December 2012. The only communication from the dialysis center noted for the month of January 2013 was 1/29 and 1/31/13.</p> <p>A quarterly dietary progress note, dated 12/7/12, indicated the resident had a 1500 ml daily fluid restriction. The current Fluid Distribution Sheet indicated the resident was to receive 1200 ml of fluid from the dietary department daily and 300 ml fluid from the nursing department daily. The form lacked any division of the 1200 ml between the three meals to be provided by the dietary department. The allotted division for the nursing department was 100 ml each for the day, evening, and night shifts. The dietary meal tickets for Resident #90 indicated 360 ml were to be given with breakfast, 480 ml with lunch, and 360 ml at supper for a total of 1200 ml daily.</p> <p>The clinical record contained food consumption records which monitored the resident's fluid intake with each meal, but did not record the amount</p>						

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of fluid consumed at any other time of the day.</p> <p>The clinical record contained nursing intake records from 12/22/12 through 1/22/13. The intake records contained information for the day shift intake only. The clinical record lacked any method to monitor the 24 hour fluid restrictions ordered by the physician.</p> <p>During an interview with the DoN and RN consultant on 2/4/13 at 11 a.m., additional information was requested related to the lack of communication with the dialysis provider following treatments, the lack of assessment and monitoring of resident following dialysis treatments and in accordance with the resident's plan of care, and the lack of 24 hour fluid restriction monitoring.</p> <p>During an interview on 2/4/13 at 4:50 p.m., the RN consultant indicated the facility had no additional information to provide related to the concerns noted above.</p> <p>A3.) The 9/05, "Policy and Procedure for Management of dialysis-- -Peritoneal and Hemo" was provided at 3:44 p.m. on 2/4/13, by the RN Consultant. The policy indicated the</p>			

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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	<p>following: "Purpose: To coordinate the care and management of the Dialysis patient with the renal clinic of their choice. Procedure: ...7. Routine communication via written and/or telephone will occur between the facility charge nurses and the clinic nurses to assure that the care is continuous and consistent.... Hemodialysis: General care guidelines, unless otherwise instructed by Physician: 1. Preventing infection to the access: Keep the graft or fistula (access) clean with soap and water. Use an anti-bacterial soap such as dial.... Notify the physician immediately if: Access if inflamed or edematous. Any type of drainage is noted from access. Pain in the access site. Fever that cannot be connected to any other condition. 2. Maintaining access blood flow: Check for blood flow by feeling for a pulse or a rushing sensation (thrill) on the access site. This thrill or pulse indicated that the blood is flowing properly thur [sic] the access.... Notify the physician immediately if: Hands and/or feet are much colder than normal. Pain in or around access. Loss or weakening of thrill. 3. Prevention of bleeding at the access: ...Do not use that part of the body for obtaining blood pressure, giving injections, or IV's. Instruct the</p>			

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 02/04/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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	<p>resident not to put pressure on that part of the body when laying. Loose clothing at the access is necessary to prevent pressure...."</p> <p>The 11/12/08, "Fluid Restriction Policy" was provided by the RN Consultant at 3:44 p.m. on 2/4/13. The policy indicated "Policy: It is the policy of the Dietary Department to follow guidelines for a Physician-ordered fluid restriction. Procedure: 1. Nursing will provide the Dietary department with an order for the exact amount of fluids allowable within a 24 hour period. 2. The amount of fluid may be recorded in "ml's" [milliliters.] 3. The Dietary Supervisor will work with the Nursing staff to assess how much fluid is required for medicine passes throughout all shifts. 4. After the amount necessary for Nursing needs is determined, Dietary will provide ALL remaining needs. 5. Fluids should be distributed evenly throughout the day (meal times, snack times, nursing shifts...."</p> <p>B1.) The clinical record for Resident #51 was reviewed on 1/31/13 at 10:35 a.m.</p> <p>Diagnoses for the resident included,</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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	<p>but were not limited to, diabetes mellitus, diabetic neuropathy, and obsessive compulsive disorder.</p> <p>A health care plan problem, dated 12/18/12, indicated Resident #51 had a diagnosis of diabetes mellitus and was at risk for experiencing both low and/or high blood sugar levels. Approaches for this problem included, but were not limited to, the following:</p> <p>"Observe for signs and symptoms of hypoglycemia.... If a blood glucose is below 60 with or without symptoms, provide the resident with one of the following.... six saltine crackers or 3 graham crackers with one tablespoon of peanut butter, one carton of 2% milk 8 ounces, 1/2 cup container of ice cream, 12 ounces of juice, or other snack at least 150 calories.... Repeat blood glucose test 10-15 minutes later.... If the interventions are not successful in increasing the blood glucose, the medical doctor will be notified immediately. Document the results of the blood glucose tests, notification of the medical doctor, responsible party, specific treatment used, residents response to treatment, and any follow up."</p> <p>A recapitulation of physician orders, dated 1/15/13, indicated resident #51</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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	<p>had diabetic related orders which included, but were not limited to, the following:</p> <p>Insta-Glucose 40% gel (a medication given to raise the blood sugar levels) - give 31 grams by mouth as needed for blood sugar below 60 and resident conscious.</p> <p>Humulin 70/30 insulin-give 34 units subcutaneously bid (two times daily)</p> <p>Lantus insulin-10 units subcutaneously daily</p> <p>Call MD (medical doctor) for BS (blood sugar) below 60 or above 400</p> <p>Accucheck before meals and at bedtime (no sliding scale insulin ordered for this resident)</p> <p>The "Blood Glucose Monitoring Records" for December 2012 and January 2013 indicated accuchecks were to be completed at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m. The records indicated the following:</p> <p>12/27/12 at 6:30 a.m.-The resident's blood sugar was recorded as 53. The form indicated "gave food to increase blood sugar." The clinical record lacked any documentation of</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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	<p>insta-glucose being given as ordered, what food was given, any recheck of the resident's blood sugar or follow-up assessment of the resident, and/or any physician notification of the low blood sugar reading.</p> <p>1/6/13 at 6:30 a.m. The resident's blood sugar was recorded as 39. The form indicated "OJ (orange juice) given." The clinical record lacked any documentation of insta-glucose being given as ordered, how much OJ was given, any recheck of the resident's blood sugar or follow-up resident assessment, and/or any physician notification of the low blood sugar reading.</p> <p>1/6/13 at 11:30 a.m. The resident's blood sugar was recorded as 55. The form indicated "OJ was given." The clinical record lacked any documentation of insta-glucose being given as ordered, how much OJ was given, any recheck of the resident's blood sugar or follow-up assessment, and/or any physician notification of the low blood sugar reading.</p> <p>1/11/13 at 6:30 a.m. The resident's blood sugar was recorded as 55/51. [taken twice] The form indicated "OJ was given" and the resident's blood sugar was 92 when rechecked. The</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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	<p>clinical record lacked any documentation of insta-glucose being given as ordered, how much OJ was given, and/or any physician notification of the low blood sugar reading.</p> <p>1/12/13 at 6:30 a.m. The resident's blood sugar was recorded as 39. The form indicated "PBJ" (peanut butter and jelly) was given and the resident's blood sugar was 76 when rechecked. The clinical record lacked any documentation of insta-glucose being given as ordered and/or any physician notification of the low blood sugar reading.</p> <p>1/13/13 at 9:00 p.m. the resident's blood sugar was recorded as 405. The clinical record lacked any documentation of the physician having been notified of the blood sugar above 400 as ordered by the physician.</p> <p>1/14/13 at 9:00 p.m. the resident's blood sugar was recorded as 429. The clinical record lacked any documentation of the physician having been notified of the blood sugar above 400 as ordered by the physician.</p> <p>The clinical record lacked any</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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	<p>documentation of the glucometer checks having been completed as ordered on the following dates and times:</p> <p>12/13, 14, 15, 16, 2012 at 9:00 p.m. 12/24/12 at 6:30 a.m. 12/25/12 at 11:30 a.m., 4:30 p.m., and 9 p.m.</p> <p>During an interview with the DoN and RN consultant on 2/4/13 at 11 a.m., additional information was requested related to the lack of the insta glucose gel having been given as ordered for the blood sugars below 60, the lack of specific food information given, the lack of followup blood sugar monitoring having been completed, the lack of physician notification of the low blood sugar readings, and the missing accucheck information.</p> <p>During an interview on 2/4/13 at 4:50 p.m., the RN consultant indicated the facility had no additional information to provide related to the concerns noted.</p> <p>B2.) The clinical record for Resident #90 was reviewed on 2/1/13 at 1 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic renal</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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	<p>failure, end stage renal disease, diabetes mellitus type 2, history of non compliance, and bipolar disorder.</p> <p>A recapitulation of physician orders, dated 12/30/12, indicated resident #90 had diabetic related orders which included, but were not limited to, the following:</p> <p>Levemir insulin 20 units subcutaneously daily. The original date of this order was 4/27/12.</p> <p>Accucheck before meals and at bedtime. (original order date 4/27/12)</p> <p>Novolog insulin per sliding scale (SS) before meals and at bedtime: 0-120= 0 units 121-150= 2 units 151-200=4 units 201-250=6 units 251-300=8 units 301-350=10 units 351-400=12 units 401=999=15 units Recheck in 2 hours (original order date 4/30/12)</p> <p>Call MD (medical doctor) for BS (blood sugar) below 60 or above 400 (original order date 7/12/12)</p> <p>The "Blood Glucose Monitoring</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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	<p>Records" for December 2012 and January 2013 indicated accuchecks were to be completed at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m. The records indicated the following:</p> <p>12/7/12 at 4:30 p.m.-The resident's blood sugar was recorded as 409. 15 units of Novolog SS insulin coverage was given. The clinical record lacked any recheck of the resident's blood sugar or physician notification of the high blood sugar reading.</p> <p>12/21/12 at 6:30 a.m. - BS 127- "0" insulin given- should have been 2 units</p> <p>12/22/12 at 9 p.m. - BS 149-"0" no insulin given-should have been 2 units</p> <p>No accucheck was documented as having been completed as ordered on 12/5 at 9 p.m., 12/8 at 9 p.m., 12/22 at 6:30 a.m., 12/30/12 at 9 p.m.</p> <p>1/15/13 at 6:30 a.m.-BS 210-4 units given, should have been 6 units given 1/15/13 at 11:30 a.m. - BS 169-2 units given, should have been 4 units given 1/31/13 at 6:30 a.m.- BS 148-4 units given, should have been 2 units given 1/28/13 at 11:30 a.m.-BS 160 -2 units</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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	<p>given, should have been 4 units given</p> <p>The Medication Administration Records (MAR) and nursing notes lacked any information related to the Levemir insulin having been given as ordered on January 2, 3, 7, 8, 11, 12, 13, and 15, 2013.</p> <p>During an interview with the DoN and RN consultant on 2/4/13 at 11 a.m., additional information was requested related to the incorrect insulin having been given on the dates noted above, the lack of documentation of the Levemir insulin having been given on the dates noted above, and the missing accucheck readings noted above.</p> <p>During an interview on 2/4/13 at 4:50 p.m., the RN consultant indicated the facility had no additional information to provide related to the concerns noted above.</p> <p>B3.) The clinical record for Resident #55 was reviewed on 2/1/13 at 9:50 a.m.</p> <p>Diagnoses for Resident #55 included, but were not limited to, diabetes mellitus, hypertension, depression, and congestive heart failure.</p> <p>Resident #55 had current physician's</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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	<p>orders for the following,</p> <p>a. Monitor blood glucose levels before meals and at bedtime: 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m. The original date of this order was 9/6/12.</p> <p>b. Administer Novolog sliding scale insulin coverage based on blood glucose results according to the scale below,</p> <p>121 - 150 = 2 units 151 - 200 = 4 units 201 - 250 = 6 units 251 - 300 = 8 units 301 - 350 = 10 units 351 - 400 = 12 units 401 - 999 = 12 units less than 70 call physician or greater than 400 call physician</p> <p>The original date of this order was 9/6/12.</p> <p>Review of the November 2012, December 2012, and January 2013 "Blood Glucose Monitoring Record," Medication Administration Record (MAR) and nurses notes for Resident #55 lacked any indication the physician ordered blood glucose monitoring had been completed on the following dates and times,</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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	<p>November 2, at 9:00 p.m. November 12, at 9:00 p.m. November 16, at 9:00 p.m. November 20, at 9:00 p.m. November 23, at 9:00 p.m. November 24, at 9:00 p.m. November 29, at 9:00 p.m. December 5, at 11:30 a.m. December 8, at 6:30 a.m. December 8, at 11:30 a.m. December 15, at 4:30 p.m. December 15, at 9:00 p.m. December 16, at 6:30 a.m. January 16, at 6:30 a.m. January 23, at 6:30 a.m. January 30, at 6:30 a.m.</p> <p>During an interview with the DoN (Director of Nursing), RN Consultant, and Administrator on 2/4/13 at 10:54 a.m., additional information was requested related to the lack of blood glucose monitoring for Resident #55 on the dates and times noted.</p> <p>During an interview with the RN consultant on 2/4/13 at 4:50 p.m., she indicated she had no other information to provide related to the blood glucose monitoring for Resident #55 on the dates and times noted.</p> <p>B4.) The 9/05, "Blood Glucose Monitoring Procedure" was provided by the RN Consultant at 3:44 p.m. on</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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	<p>2/4/13. The procedure indicated the following: "Purpose: To obtain a quantitative measure of blood glucose as ordered by the physician.... 14. Document the results on the appropriate flow record."</p> <p>The undated "Injections, Insulin" policy was provided by the RN Consultant at 3:44 p.m. on 2/4/13. The policy indicated the following: "Purpose: Insulin is injected to aid oxidation and utilization of the blood sugar by the tissues, and to control blood sugar levels in residents with Diabetes Mellitus. Policy: Insulin is administered by licensed personnel as ordered by the physician...."</p> <p>3.1-37(a)</p>			

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 02/04/2013
NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012		
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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who was dependent on staff assistance for oral hygiene needs received staff assistance for daily teeth brushing for 1 of 2 residents who meet the criteria for activities of daily living. (Resident #21)</p> <p>Findings include:</p> <p>During a 1/29/13, 11:21 a.m. interview with Resident #21, who had been identified as interviewable during the stage 1 screening, Resident #21 indicated she required staff assistance to brush her teeth. She could not remember the last time her teeth had been brushed. She indicated she had an electric toothbrush in the bathroom and would require the staff to set it up for her in order to brush her teeth.</p> <p>Resident #21's clinical record was reviewed on 2/4/13, 8:34 a.m.</p>	F0312	<p>1. Resident #21 was provided oral care upon notification of concern. Resident #21 incurred no negative outcome. 2. All residents who require assistance with oral care have the potential to be affected. All residents who require assistance with oral care have been assessed and oral care has been provided as warranted. 3. The facility's policy and procedure for oral care has been reviewed and no changes were made. (See attachment 13-A-B) All nursing staff has been re-educated on the policy and procedure. (See attachment 2-A-B-C-D-E) 4. The DON or her designee will monitor for provision of oral care provided to 3 residents on each unit daily on scheduled days of work for one month, two times weekly for one month then weekly thereafter until compliance is maintained for 6 months. (See attachment 14) Should concerns be observed, re-education will be provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>	02/25/2013	

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 02/04/2013
NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012		
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	<p>Resident #21's current diagnoses included, but were not limited to, right side weakness, depression and severe anxiety.</p> <p>Review of a current, 10/27/12, annual Minimum Data Set Assessment indicated the resident was cognitively intact, understood others, was understood by others, had impairment on one side of both her upper and lower extremities and was totally dependent on staff assistance for all hygiene needs.</p> <p>Resident #21 had an 11/19/12 care plan problem which indicated she needed assistance with all activities of daily living. An approach was to provide assistance as needed.</p> <p>Review of a current, 12/17/12, facility form titled "CNA Assignment Sheet Team 4 Day and Evening Shift," which was provided by the Director of Nursing on 2/4/12 at 1:00 p.m., indicated Resident #21 needed staff assistance with oral hygiene.</p> <p>During a 2/4/13, 1:10 p.m., interview, Resident #21 indicated she had yet to get her teeth brushed. During an observation at this time, Resident #21's teeth were noted to be thickly covered with tartar and plaque.</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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	<p>Resident #21's toothbrush was in the bathroom and dry to the touch.</p> <p>During a 2/4/13, 1:27 p.m., interview, CNA #2 indicated she was Resident #21's CNA for the day shift. She indicated she had not yet brushed Resident #21's teeth for the day. She indicated she had not worked all weekend so did not know if Resident #21's teeth had been brushed over the weekend.</p> <p>During a 2/4/13, 1:35 p.m. interview, RN #3 observed Resident #21's teeth and indicated they needed brushed and there was a build-up of significantly more than one day's plaque and tartar.</p> <p>3.1-38(a)(3)(c)</p>			

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 02/04/2013
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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure a resident with a tracheostomy received the respiratory services of oxygen saturation monitoring every shift as ordered by the physician for 1 of 1 resident observed with a tracheostomy. (Resident #55)</p> <p>Findings include:</p> <p>The clinical record for Resident #55 was reviewed on 2/1/13 at 9:50 a.m.</p> <p>Diagnoses for Resident #55 included, but were not limited to, diabetes mellitus, hypertension, depression, and congestive heart failure.</p> <p>The resident had a current physician's order for oxygen saturations (sats) every shift and as needed.</p> <p>A current health care plan problem for</p>	F0328	<p>1. Resident #55 oxygen saturation had been obtained on the date of the notification of concern. Resident #55 incurred no negative outcome. 2. All residents who have physician orders to monitor oxygen saturation have the potential to be affected. The clinical records for all residents who have orders to monitor their oxygen saturation have been reviewed to ensure oxygen saturation is being obtained as ordered. 3. The facility's policy and procedure for monitoring oxygen saturation has been reviewed and no changes have been made. (See attachment 15-A-B) The nurses have been re-educated on the policy and procedure. (See attachment 2-A-B-C-D-E). Oxygen saturation obtained by licensed nursing staff will be recorded on the MAR, thus accessible to nursing staff at all times. 4. The DON or her designee will monitor all residents who have orders for monitoring of</p>	02/25/2013

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 02/04/2013
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	<p>Resident #55, dated 8/16/11, indicated the resident was at risk for decreased oxygen saturation due to his tracheostomy. One approach for this problem was "Monitor oxygen saturation at least every shift."</p> <p>Review of the December 2012, Medication Administration Record (MAR), respiratory notes, and nurses notes for Resident #55 lacked any indication the physician ordered oxygen saturation monitoring had been completed on every shift for the following dates,</p> <p>December 1, evening and night shifts December 2, evening and night shifts December 3, night shift December 4, night shift December 5, night shift December 6, evening and night shifts December 7, evening and night shifts December 8, evening and night shifts December 9, evening and night shifts December 10, night shift December 11, evening and night shifts December 12, night shift December 13, night shift December 14, evening and night shifts December 15, evening and night shifts December 16, evening and night</p>		<p>their oxygen saturation on scheduled days of work daily for one month, two times weekly for one month, then weekly thereafter until compliance is maintained for 6 months. (See attachment 16) Should non-compliance be noted, immediate corrective action shall be taken. The results of these observations will be discussed in the quarterly QA meetings and the plan of action adjusted accordingly, as warranted.</p>		

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	<p>shifts December 17, evening and night shifts December 18, evening and night shifts December 19, night shift December 20, evening and night shifts December 21, evening shift December 22, evening shift December 23, evening and night shifts December 24, night shift December 25, evening and night shifts December 26, night shift December 27, night shift December 28, evening and night shifts December 29, evening and night shifts December 30, night shift December 31, night shift</p> <p>During an interview with the DoN (Director of Nursing), RN Consultant, and Administrator on 2/4/13 at 10:54 a.m., additional information was requested related to the lack of oxygen saturation monitoring for Resident #55 on the dates and times noted.</p> <p>During an interview with the DoN on 2/4/13 at 11:16 a.m., she indicated respiratory services were in the facility</p>				

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	<p>12 hours a day not 24 hours a day.</p> <p>During an interview with the DoN on 2/4/13 at 2:20 p.m., she indicated the oxygen saturation monitoring for every shift was maintained in the respiratory services computer. She indicated the facility staff did not have access to the respiratory services computer.</p> <p>The 8/09 revised "Pulse Oximetry" policy was provided by the RN Consultant at 5:18 p.m. on 2/4/13. The policy indicated "Pulse oximetry is a non-invasive method of acquiring data on the ratio of oxygenated hemoglobin to the total hemoglobin.... Document outcome of procedure in the resident's medical record including: a. date and time of procedure b. results obtained...."</p> <p>3.1-47(a)(4)</p>				

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure a resident did not receive psychoactive medications without identified targeted behaviors, documented behavioral indicator for use, or non-chemical interventions attempted prior to the administration of "as need" psychoactive medications, for 1 of 10 residents who meet the criteria for unnecessary medications. (Resident #74)</p>	F0329	<p>1. The current medication orders for resident # 74 have been reviewed and clarified to ensure that all ordered PRN psychoactive medications have identified target behaviors as a rationale for use, behaviors that warrant the use of psychoactive medications are documented(i.e. behavior memo), and that non pharmacological interventions were attempted prior to the use of PRN psychoactive. 2. All residents who have ordered PRN psychoactive medications have the potential to be affected. The</p>	02/25/2013			

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	<p>Findings include;</p> <p>Resident #74's clinical record was reviewed on 2/4/13 at 3:00 p.m.</p> <p>Resident #74's current diagnoses included, but were not limited to, anxiety, Alzheimer's disease and post cerebral vascular accident (stroke).</p> <p>Resident #74 had current 2/13 physician's orders for the following psychoactive medications:</p> <p>a.) Zoloft (antidepressant) 100 mg - 1 tablet 1 time daily, give with 25 mg to total 125 mg. This order originated 1/14/13.</p> <p>b.) Zoloft 25 mg - 1 tablet 1 time daily, give with 100 mg to total 125 mg. This order originated 1/14/13.</p> <p>c.) Seroquel (anti-psychotic) 25 mg - 1 tablets 2 times daily. This order originated 1/14/13.</p> <p>d.) Zyprexa (anti-psychotic) 2.5 mg - 1 tablet 2 times daily. This order originated 1/23/13.</p> <p>e.) Haloperidol Lac (Haldol-antipsychotic) 5 mg/ml vial-inject 1 ML (5 mg) every 8 hours as needed (no criteria for use). This</p>		<p>clinical records for all residents who have orders for PRN psychoactive medications have been reviewed to ensure they have identified target behaviors as a rational for use of the PRN psychotropic, administration of PRN psychotropic has been correctly documented(i.e. behavior memo) and non-pharmacological interventions were attempted prior to administration of PRN psychoactive and documented.</p> <p>3. The policy and procedure related to PRN psychoactive medications has been reviewed and no changes were made. (See attachment 5-A-B-C-D-E-F-G-H-I) The nurses were re-educated on the policy and procedure in regard to administration of PRN psychoactive medications. (See attachment 2-A-B-C-D-E) 4. The DON or her designee will monitor the administration of PRN psychoactive medication to ensure the appropriate documentation to support PRN administration is in place, target behaviors are identified and that non-pharmacological interventions were attempted prior to administration on scheduled days of work daily for one month, two times weekly for one month, then weekly thereafter until compliance is maintained for 6 months. (See attachment 6) Should non-compliance be noted, immediate corrective action shall</p>				

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	<p>order originated 1/23/13.</p> <p>f.) Ativan (anti-anxiety) 1 mg - 1 mg give 1 tablet as needed every 4 hours (no criteria for use). This order originated 1/14/13.</p> <p>g.) Zyprexa (anti-psychotic) 2.5 mg - 1 tablet as needed every 6 hours (no criteria for use). This order originated 1/23/13.</p> <p>Resident #74 had a 1/14/13 hospital discharge summary which indicated:</p> <p>a.) He had been hospitalized for geri-psych needs from 1/4/13 to 1/14/13.</p> <p>b.) His mood had improved since admission.</p> <p>c.) He had become cooperative with activities of daily living.</p> <p>d.) He continued to be confused.</p> <p>e.) His psychoactive medications at discharge were: Zoloft 125 mgs daily Seroquel 25 mgs twice daily Ativan 1 mg as needed (no times listed).</p> <p>During a 2/4/13, 3:15 p.m. interview</p>		<p>be taken. The results of these observations will be discussed in the quarterly QA meetings and the plan of action adjusts accordingly, as warranted.</p>				

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	<p>with the Assistant Director of Nursing #4 (ADoN) indicated, when Resident #74 returned from the hospital on 1/14/13 the ADoN had contacted the resident's primary care physician that same day and asked for the resident's Haloperidol order to be reinstated because it had been used prior to hospitalization. The ADoN indicated the resident was not displaying any behaviors at the time the call was made. He indicated he just wanted it available if needed. When queried regarding the non-use of this medication in the hospital and the reinstatement upon Resident #74's readmission, he indicated he had wanted to be prepared. The ADoN additionally indicated there was no criteria regarding the use of the as needed psychoactive medications and which medication should be used first or under what condition each medication should be used.</p> <p>Review of Resident #74's "PRN [as needed] Medication Flow Sheet" for January and February (2/1/13 to 2/4/13) 2013 indicated the resident received 14 doses of the as needed psychoactive medications during this period. Of the 14 doses 8 lacked documentation of a description of the behavioral event or documentation if any non-chemical interventions had</p>				

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	<p>been attempted prior to the administration of the medications. The 8 events were as follows:</p> <p>a.) 1/2/13, 12:05 a.m.-Ativan 1 mg given for "anxiety." b.) 1/4/13, 7:30 a.m.-Ativan 1 mg given for "anxiety." c.) 1/22/13, 10:00 a.m.-Haldol 5 mg given for "agitation." d.) 1/29/13, 4:45 (a.m. or p.m. not indicated)- Haldol 5 mg given- no other documentation. e.) 1/29/13, 4:15 (a.m. or p.m. not indicated)- Ativan 1 mg given for "agitation." f.) 1/13/13, 2:40 p.m.-Haldol 5 mg given for "agitation." g.) 1/31/13, 3:05 p.m.-Ativan 1 mg given for "agitation." h.) 2/1/13, 6:00 p.m.-Haldol 5 mg given for "agitation."</p> <p>During a 2/4/13, 4:00 p.m. interview, The Social Service Designee indicated he had no other behavioral documentation to provide regarding the 8 doses of as needed medication.</p> <p>On 1/23/13, Resident #74 was started on an additional routine and as needed anti-psychotic medication of Zyprexa 2.5 mg two times daily and 2.5 mg every 6 hours as needed. The "Nursing Progress Notes" for 1/14/13 through 1/22/12 indicated the</p>			

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	<p>resident had displayed behaviors on 1/22/13. This was the only behavior documented during this 8 day period since his hospital readmission. On 1/22/12 Resident #74 displayed agitation and had been treated with Haldol and had responded to the medication. The "Behavioral Monthly Flow Record for 1/14/13 to 1/23/13 contained no behavioral documentation. The record lacked any documentation of any behavioral symptoms which would result in an increase of anti-psychotic medication on 1/23/13.</p> <p>During a 2/4/13, 3:15 p.m. interview, Assistant Director of Nursing #4 (ADoN) indicated did not know why Resident #74 was started on Zyprexa 1/23/13. He had no other behaviors other than the 1/22/13 event when Haldol was given and was effective. The facility had no supporting documentation of behaviors or a medical reason for the addition of Zyprexa to the resident's drug regimen on 1/23/13.</p> <p>The clinical record lacked documentation of any identified specific targeted behaviors being treated by the anti-anxiety and anti-psychotic medications. The "Behavior Monthly Flow Record" for</p>						

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	<p>December 2012 January and February 2013 did not contain specific behaviors for tracking and had broad behavioral symptoms as follows: signs and symptoms of anxiety, social inappropriate behaviors and wandering exit seeking. During an 2/4/13, 4:50 p.m., interview, the the Social Service Consultant indicated the facility did not identify specific target behaviors and tracked general behaviors on the flow records. He additionally indicated when an behavioral event occurred the "Mood and Behavior Communication Memo" should be completed. When queried if a behavior memo should have accompanied all the as needed psychoactive medication used, he indicated yes.</p> <p>The 3/07, "Antipsychotic Drug Use Policy" was provided by the Director of Nursing on 2/4/13 at 3:00 p.m. The policy indicated the following:</p> <p>"Purpose: To ensure that anti-psychotic drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Non-pharmacological interventions will be considered and used when</p>						

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	<p>indicated, instead of or in addition to, medication.... Since the diagnoses alone do not warrant the use of antipsychotic medications, the clinical condition must also meet at least one of the following criteria (a or b or c):...b. The behavioral symptoms present a danger to the resident or to others; OR c. The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with end-of-life, or crying); a significant decline in function; and or substantial difficulty receiving needed care.... Not due to environmental stressors...Not due to psychological stressors... Inadequate Indications: In many situations, antipsychotic medications are not indicated. They should not be used if the only indication is one or more of the following:...12) verbal expressions or behaviors that are not due to the conditions listed under "Indications" and do not represent a danger to the resident or others.... Daily Dose Thresholds for Antipsychotic Medications Used to Manage Behavioral Symptoms Related to Dementing illness...haloperidol (Haldol) 2 mg [milligram]...."</p>			

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	<p>The 3/07, "Antianxiety Drug Use Policy" was provided by the Director of Nursing on 2/4/13 at 3:00 p.m. The policy indicated the following: "Purpose: To ensure that anti-anxiety drugs will be administered only when medically indicated to treat a specific condition and help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Non-pharmalogical interventions will be considered and used when indicated, instead of, or in addition to medication.... Appropriate diagnosis or conditions for use.... 7. Delirium, dementia, and other cognitive disorders with associated behaviors that: - Are quantitatively and objectively documented; - Are persistent; - Are not due to preventable or correctable reasons; and - Constitute a clinically significant distress or dysfunction to the resident or represent a danger to the resident or others. Evidence exists that other possible reasons for the individual's distress have been considered...."</p> <p>3.1-48(a)3 3.1-48(a)4 3.1-48(b)(1)</p>				

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was refrigerated at a safe temperature for 2 of 2 refrigerators reviewed. This deficient practice had the potential to impact 70 of the facility's 71 residents who ate food prepared in the kitchen.</p> <p>Findings include:</p> <p>During the 1/29/13, 9:40 a.m. initial kitchen sanitation tour the following refrigeration concerns were observed:</p> <p>a.) The walk-in refrigerator had an internal thermometer which registered 50 degrees Fahrenheit. Multiple food items were stored in the walk-in refrigerator. Food items included, but were not limited to, eggs, ham, hamburger, cheese and Mighty Shakes (a protein based health shake). Upon request, the Dietary Manager tested a Mighty Shake, which had been stored in the walk-in refrigerator. The Mighty Shake</p>	F0371	<p>1. The walk in refrigerator and reach-in refrigerator were repaired upon notification of the temperature concerns. Following repair, both were in acceptable temperature range. 2. As all residents of the facility have the potential to be affected, the following corrective actions were taken: 3. The facility's policy and procedure for monitoring the refrigerator temperatures (including use of logs to document said monitoring) has been reviewed and no changes were made. (See Attachment 17) The Dietary Manager and all dietary employees have been re-educated on the policy and procedure, including necessary documentation of temperatures. (See attachment 18) 4. The Dietary Manager or corporate dietary personnel or designee will monitor temperature logs and temperature and check internal temperatures of potentially hazardous, refrigerated foods at least 5 times per week. (See attachment 19-A) The Administrator or his designee will monitor the temperatures in the walk in and reach in refrigerators</p>	02/25/2013			

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 02/04/2013	
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	<p>registered a temperature of 50 degrees Fahrenheit.</p> <p>b.) The reach-in refrigerator had an internal thermometer which registered 48 degrees Fahrenheit. Multiple food items were stored in the reach-in refrigerator. Food items included, but were not limited to, Mighty Shakes and pre-poured milk and juice. Upon request, the Dietary Manager tested a Mighty Shake, which had been stored in the reach-in refrigerator. The Mighty Shake registered a temperature of 48 degrees Fahrenheit.</p> <p>During a 1/29/13, 9:55 a.m. interview, the Dietary Manager indicated the facility maintained a temperature log for both refrigerators. Upon request at this time, the Dietary Manager obtained the refrigerator temperature logs. He then indicated he could only find one sheet. He additionally indicated the sheets lacked identification as to which refrigerator's temperature had been recorded.</p> <p>Review of the January 2013 "Refrigerator Temperature Log" (1/1/13 to 1/28/13) which was provided by the Dietary Manger on 1/29/13 at 10:00 a.m. indicated the following:</p>		<p>on scheduled days of work daily for one month, two times weekly thereafter until compliance is maintained for 6 months. (See attachment 19-B) Should concerns be observed, re-education will be provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>				

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	<p>a.) The log did not indicate which refrigerator was being monitored.</p> <p>b.) The log indicated refrigerator temperatures should be below 41 degrees Fahrenheit.</p> <p>c.) The log had two entries per day "A.M. Temp" and "P.M. Temp."</p> <p>d.) 56 entries had been made for the month of January 2013. All 56 entries recorded the same temperature of 40 degrees Fahrenheit.</p> <p>During a 1/29/13, 11:30 a.m. interview, the Corporate Dietary Consultant indicated it is very unlikely for a refrigerator to not vary in temperature at least a degree or two, She additionally indicated the facility should have had two "Refrigerator Temperature Logs" and each form should indicate which refrigerator was being monitored.</p> <p>During a 2/4/13 at 10:35 a.m. interview, the Director of Nursing indicated 70 of the facility's 71 residents ate meals which were prepared in the facility's kitchen.</p> <p>During a 2/4/13, 3:00 p.m. interview, the Administrator indicated the facility</p>			

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	<p>did not have a policy which addressed the required temperatures of refrigeration units. He additionally indicated the facility only had a policy regarding food temperatures at the point of service not when being held in a refrigerator.</p> <p>Review of an 11/12/2008 facility policy, titled "Storage of Leftovers," which was provided by the Administrator on 2/4/13 at 3:00 p.m., indicated the following: "All cold food should be held and served at 41F [Fahrenheit] or below."</p> <p>3.1-21(i)(3)</p>			

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F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the pharmacy consultant noted irregularities in the resident's diabetic monitoring, insulin administration, and medication administration for 2 of 5 residents reviewed for pharmacy services related to insulin use. (Resident #'s 51 and 90)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #51 was reviewed on 1/31/13 at 10:35 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, diabetes mellitus, diabetic neuropathy, and obsessive compulsive disorder.</p> <p>A recapitulation of physician orders, dated 1/15/13, indicated resident #51 had diabetic related orders which included, but were not limited to, the following:</p>	F0428	<p>1. Concerns identified in the medication administration records of Resident's # 51 and 90 clinical records have been reviewed with the pharmacy consultant. 2. All diabetic residents have the potential to be affected by failure to identify irregularities in the resident's diabetic monitoring, insulin administration, and medication administration as per physician's order. As such, the medical records of all diabetic residents will be reviewed and any irregularities noted addressed with the consultant pharmacist and attending physician, as warranted. 3. The facility's policy and procedure on Consultant Pharmacist has been reviewed and no changes were made. (See attachment 20-A-B) The consultant pharmacist has been provided a copy of the policy and procedure. All irregularities discovered during the aforementioned audit will be addressed with the consultant pharmacist. 4. The DON or her designee will review the consultant pharmacist drug</p>	02/25/2013	

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 02/04/2013
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	<p>Insta-Glucose 40% gel (a medication given to raise the blood sugar levels) - give 31 grams by mouth as needed for blood sugar below 60 and resident conscious.</p> <p>Humulin 70/30 insulin-give 34 units subcutaneously bid (two times daily)</p> <p>Lantus insulin-10 units subcutaneously daily</p> <p>Accucheck before meals and at bedtime (no sliding scale insulin ordered for this resident)</p> <p>The "Blood Glucose Monitoring Records" for December 2012 and January 2013 indicated accuchecks were to be completed at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m. The records indicated the following:</p> <p>12/27/12 at 6:30 a.m.-The resident's blood sugar was recorded as 53. The clinical record lacked any documentation of insta-glucose being given as ordered.</p> <p>1/6/13 at 6:30 a.m. The resident's blood sugar was recorded as 39. The clinical record lacked any documentation of insta-glucose being given as ordered.</p>		<p>regimen review on a monthly basis to ensure that thorough review includes any irregularities related to blood glucose monitoring and medication administration, including diabetic medications, monthly until compliance is maintained for 6 months. (See attachment 21) Should concerns be observed, re-education will be provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>		

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	<p>1/6/13 at 11:30 a.m. The resident's blood sugar was recorded as 55. The clinical record lacked any documentation of insta-glucose being given as ordered.</p> <p>The clinical record lacked any documentation of the glucometer checks having been completed as ordered on the following dates and times:</p> <p>12/13, 14, 15, 16, 2012 at 9:00 p.m. 12/24/12 at 6:30 a.m. 12/25/12 at 11:30 a.m., 4:30 p.m., and 9 p.m.</p> <p>During an interview with the DoN and RN consultant on 2/4/13 at 11 a.m., additional information was requested related to the date of pharmacy visits and whether any recommendations had been made regarding the low blood sugar readings without documentation of the insta glucose gel having been given and the missing accucheck information.</p> <p>During a review of pharmacy regime reviews, provided by the DoN on 2/4/13 at 2:30 p.m., the following was noted:</p> <p>The pharmacy consultant reviewed</p>						

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	<p>resident #51's clinical record sometime between 12/1 and 12/31/12 and again between 1/1 and 1/10/13. No recommendations were made regarding the noted concerns.</p> <p>2.) The clinical record for Resident #90 was reviewed on 2/1/13 at 1 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, chronic renal failure, end stage renal disease, diabetes mellitus type 2, history of non compliance, and bipolar disorder.</p> <p>A recapitulation of physician orders, dated 12/30/12, indicated resident #90 had diabetic related orders which included, but were not limited to, the following:</p> <p>Levemir insulin 20 units subcutaneously daily. The original date of this order was 4/27/12.</p> <p>Accucheck before meals and at bedtime. (original order date 4/27/12)</p> <p>Novolog insulin per sliding scale (SS) before meals and at bedtime: 0-120= 0 units 121-150= 2 units 151-200=4 units 201-250=6 units 251-300=8 units</p>						

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	<p>301-350=10 units 351-400=12 units 401=999=15 units Recheck in 2 hours (original order date 4/30/12)</p> <p>The "Blood Glucose Monitoring Records" for December 2012 and January 2013 indicated accuchecks were to be completed at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m. The records indicated the following:</p> <p>12/21/12 at 6:30 a.m. - BS 127- "0" insulin given- should have been 2 units</p> <p>12/22/12 at 9 p.m. - BS 149-"0" no insulin given-should have been 2 units</p> <p>No accucheck was documented as having been completed as ordered on 12/5 at 9 p.m., 12/8 at 9 p.m., 12/22 at 6:30 a.m., 12/30/12 at 9 p.m.</p> <p>The Medication Administration Records (MAR) and nursing notes lacked any information related to the Levemir insulin having been given as ordered on January 2, 3, 7, and 8, 2013.</p> <p>During an interview with the DoN and RN consultant on 2/4/13 at 11 a.m.,</p>			

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	<p>additional information was requested related to the date of pharmacy visits and whether any recommendations had been made regarding incorrect insulin having been given for the dates noted and the missing accucheck information.</p> <p>During a review of pharmacy regime reviews, provided by the DoN on 2/4/13 at 2:30 p.m., the following was noted:</p> <p>The pharmacy consultant reviewed resident #51's clinical record between 1/1 and 1/10/13. No recommendations were made regarding the noted concerns.</p> <p>3.) The undated "Consultant Pharmacist" policy was provided by the RN Consultant at 3:44 p.m. on 2/4/13. The policy indicated the following: "A licensed pharmacist will be retained as a consultant to the facility to coordinate, supervise, and review pharmaceutical services on a regularly scheduled, on-premises basis.... The pharmacy consultant will:.... Review the drug regimen of each skilled and intermediate care resident at least monthly, as delineated in the Drug Regimen Review Policy and Procedure.... Report irregularities in drug acquisition, storage, handling,</p>						

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	<p>administration, and disposition in writing to the administrator and director of nursing...."</p> <p>3.1-25(i)</p>			

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F0465 SS=C	<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, interview, and record review, the facility failed to ensure doors, floors, cove base, and window frames were clean, neat and in good repair. This deficient practice had the potential to impact 71 of 71 facility residents.</p> <p>Findings include:</p> <p>During stage one resident room observation from 1/29/13, 10:00 a.m. to 1/30/13, 3:00 p.m., the following resident room concerns were noted:</p> <p>Resident rooms 312, 305, 301, 302, 213, 215, 303 and 313 had chipped paint on the door frame and a heavy gray, brown build-up of residue on the floor at the threshold.</p> <p>During a 2/4/13, 9:00 a.m., environmental tour accompanied by the Maintenance Supervisor, Maintenance Assistant and Housekeeping Supervisor observed concerns included, but were not limited to, the following:</p> <p>a.) The cove base down the 100,</p>	F0465	<p>1. The doorframes of resident rooms 312,305,301,302,213,215,303 and 313 will be repainted and the thresholds to these doors will be thoroughly cleaned. The cove base down the 100,200,300,400 and center hall thru the dining room will be cleaned and /or replaced to remove scuff marks. The doors and/or door frames for rooms 306,311,208,113,116,515,606,610, medication room 1&2, Medication Room 3&4, kitchen door, side exit by kitchen, gazebo door, social service office, beauty shop, 100 shower room, laundry room, 500 shower room and 400 break room will be painted, repaired and/or repainted as warranted. The floors at the thresholds of rooms 106,113,116,307,311,306,518,504,617,100 shower room, 200 shower room and 400 shower room will be thoroughly cleaned. The window frames in the dining room will be repainted. 2. Facility-wide rounds were conducted by administrative staff in an effort to identify all areas in need of cleaning/repair and said repair scheduled accordingly. 3. The facility's preventative maintenance plan has been</p>	02/25/2013			

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	<p>200, 300, 400 and center hall through the dining room was scuffed with long white marks.</p> <p>b.) Paint was chipped from door frames and/or the doors or "skins" (protective door coverings) were scuffed, scarred, marred and/or had discolored marks for resident rooms 306, 311, 208, 113, 116, 515, 606, 610, "Medication Room 1 & 2", "Medication Room 3 & 4", kitchen door, side exit by kitchen, gazebo door, social service office, beauty shop, 100 shower room, 200 shower room, laundry room, 500 shower room, and 400 break room.</p> <p>c.) Floors at the thresholds had a build up of gray brown residue in resident rooms 106, 113, 116, 307, 311, 306, 518, 504, 617, 100 shower room, 200 shower room and 400 shower room.</p> <p>d.) Paint was chipped from the window frames in the Main Dining Room.</p> <p>During a 2/4/13, 9:45 a.m. interview, the Maintenance Supervisor indicated the following:</p> <p>a.) He believed the scuff marks on the cove board could be from the buffer.</p>		<p>reviewed and no changes were made. (See attachment 22-A-B-C-D-E). Facility cleaning schedules were reviewed in an effort to increase frequency, if needed, to address specific areas of concern. The Maintenance Director and Housekeeping Supervisor and their staffs have been re-educated on maintaining a safe, functional, sanitary and comfortable environment for residents/staff and the public. (See attachment 23) 4. The Administrator or his designee will conduct facility rounds on scheduled days of work daily for one month, two times weekly for one month, then weekly thereafter until compliance is maintained for 6 consecutive months. (See attachment 4) Should any concerns be observed, they will be addressed as warranted. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>				

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	<p>b.) Keeping up door frames was an ongoing job and the facility was constantly doing touch-ups.</p> <p>c.) He felt the floor threshold build up could also be caused by the buffer.</p> <p>Review of an undated facility document titled "Housekeeping In-Service," which was provided by the Housekeeping Supervisor on 2/4/13 at 10:30 a.m., indicated the following: "Starting in a clockwise rotation from patient room door: clean, polish, scrub, scrap, dust, disinfect, sweep, wipe and mop everything in the room..."</p> <p>3.1-19(f)</p>				

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F0520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview, the facility failed to develop and implement appropriate plans of action, through their Quality Assurance Committee, to address the lack of dialysis assessment and monitoring for 2 of 2 residents (Resident #'s 90 and 33) reviewed receiving dialysis services and the lack of physician notification, accurate insulin administration, and completion of accuchecks as ordered for 3 of 5 residents (Resident #'s 51, 55, and</p>	F0520	<p>1. Areas of concern identified during the survey process have been addressed with the QA Committee and plans of correction and continued monitoring for compliance implemented. 2. As all residents have the potential to be affected, the following corrective actions have been taken: 3. The facility has held a QA meeting to address the current concerns identified and developed manners to identify specific acuity and/or care concerns for routine</p>	02/25/2013	

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 02/04/2013
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	<p>90) reviewed for diabetic services identified during the Annual Recertification and State Licensure survey.</p> <p>Findings include:</p> <p>During an interview on 2/4/13 at 3:30 p.m., the Administrator indicated the facility quality assurance program had not identified:</p> <p>Any concerns related to insufficient monitoring of dialysis residents (Resident #'s 90 and 33) or any problems related to inaccurate insulin administration, lack of accuchecks being completed or lack of physician notification of abnormal blood sugar readings for diabetic residents (Residents #'s 51, 55, and 90) within the last year.</p> <p>3.1-52(b)(2)</p>		<p>monitoring in an effort to identify specific areas of focus/concern ongoing (See attachment 24). The facility developed and implemented plans of correction to address completion of dialysis assessment and monitoring, physician notification, and accurate insulin administration, completion of accuchecks as ordered. 4. The Administrator, or his designee, will monitor all QA meetings to ensure that areas of concern are identified, action plans are developed and implemented, and efficacy evaluated in an effort to ensure compliance with the implementation of appropriate plans of action through the Quality Assurance Committee.</p>		