

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155253	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/29/2013
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NAME OF PROVIDER OR SUPPLIER  MEADOWOOD HEALTH PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 2455 TAMARACK TR BLOOMINGTON, IN 47408
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 26, 27, 28, and 29, 2013</p> <p>Facility number: 000156 Provider number: 155253 AIM number: N/A</p> <p>Survey team: Susan Worsham, RN-TC Diana McDonald, RN Melissa Gillis, RN (8/26, 8/27, and 8/29, 2013) Cheryl Mabry, RN (8/27, 8/28, and 8/29, 2013) Angela Patterson, RN</p> <p>Census bed type: SNF: 16 NCC: 34 Total: 50</p> <p>Census payor type: Medicare: 15 Other: 35 Total: 50</p> <p>NCC Sample:05</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	IAC 16.2.  Quality Review completed on September 09, 2013; by Kimberly Perigo, RN.			
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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the hot water temperature in residents' rooms were not within range of 113 to 120 degrees F (Fahrenheit) as indicated by the facility's policy and procedure for 2 of 4 residents' rooms reviewed for water temperatures. (rooms 38 and 40)</p> <p>Findings Include:</p> <p>Observation on 08/26/13 at 1:30 p.m., in Resident # 91's room, room 38. The temperature of the hot water at the sink in the bathroom measured 129.6 degrees F. Observation on 08/26/13 at 1:52 p.m., of the maintenance man using his thermometer taking the water temperature in room 38, at the bathroom sink, indicated the temperature measured 125.2 degrees F.</p> <p>Interview on 08/26/13 at 1:53 p.m.,</p>	F000323	<p>F323 – Initial audit of all rooms' water temperatures for compliance with our "Domestic Hot Water Supply Temperature Policy" will be completed by 10/7/13. Maintenance staff will be in-serviced reviewing our "Domestic Hot Water Supply Temperature" policy including the temperature range, hot water temperature controls and water temperature documentation. In-service completion date 10/1/13. Housekeeping and direct care staff will be in-serviced on the above policy and to report any noticeable increase in water temperature upon usage to the Maintenance Department for testing. In-service compliance date 10/10/13. Water temperatures will be documented 5 days a week on the daily log sheet and will be monitored by the Maintenance Director/designee daily for 30 days, weekly for 30 days then monthly. Maintenance Director/designee will monitor for compliance. Q.A. will monitor water temperature log for compliance for 6 months. When the temperature log audits have received 6 months of 100%</p>	10/01/2013	

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	<p>with the maintenance man indicated the water was too hot.</p> <p>Observation on 08/26/13 at 1:58 p.m., of the maintenance man using his thermometer taking the water temperature in room 40, at the bathroom sink, indicated the water measured 124.0 degrees F.</p> <p>Interview on 08/26/13 at 2:00 p.m., the maintenance man indicated there is one water heater for the whole facility.</p> <p>The policy for the hot water temperatures, Five Star Senior living Environment of Care Utilities Management Domestic Hot Water Supply Temperature 3.0 Procedure received on 8/26/13, at 2:45 p.m., from the Administrator indicated, "The temperature of the domestic hot water supply be between 113 and 120 degrees F."</p> <p>Risks related to time and temperature in relationship to serious burns are:</p> <p>100 degree F: safe temperature 120 degrees F: 5 min 124 degrees F: 3 min above 127 degrees F 1 min</p> <p>3.1-45(a)(1)</p>		compliance through the Q.A. process the monthly audits will be eliminated.		

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F000371 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 uncooked vegetables stored in the coolers were labeled, dated, and covered; and failed to ensure the dry storage and overhead lights were free of insects.</p> <p>Findings include:</p> <p>Observation on 8/26/13 at 8:00 a.m., of walk-in cooler #2, a metal pan sized: 13 inches by 18 inches by 2 inches, with strainer holes on the bottom and sides contained uncooked vegetables (carrots and green beans); was not labeled, dated, nor covered. A second metal pan sized: 13 inches by 18 inches by 2 inches with strainer holes on the bottom and sides contained uncooked vegetables (cauliflower, artichoke, and red peppers); was not labeled, dated, nor covered.</p> <p>Interview on 8/26/13 at 8:02 a.m., with Dietary Aide #1 indicated both</p>	F000371	<p>F371- 1) Dietary staff will be in-serviced reviewing our "Food and Safety in Receiving and Storage" policy FB-6108. In-service completion date 10/10/13. Receiving and storage will be monitored daily through the checklist located on the production sheets. The Executive Chef and/or Sous Chef will monitor for daily compliance. 2) Tomatoes previously stored in the dry storage room are to be placed in the walk in cooler and stored in a manner compliant to Five Star Policy "Food and Safety in Receiving and Storage" policy FB-6108. Labels will identify the item with date opened/received. The Executive Chef and/or Sous Chef will monitor for daily compliance through the checklist located on the production sheets. 3) All overheard lighting screens will be replaced and vent covers removed and painted. The one noted electrical wire "hanging down inside light" was fixed immediately. Through PM checks maintenance will monitor cleanliness of light covers. Maintenance Director/designee will monitor for compliance. All</p>	10/15/2013			

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	<p>pans of vegetables should have been labeled, dated, and covered with plastic wrap.</p> <p>Observation on 8/26/13 at 8:05 a.m., a box of tomatoes in the dry storage room contained half of a tomato loosely wrapped in plastic, there were 8 to 12 small flying insects in the box. Interview with Dietary Aide #1 on 8/26/13 at 8:06 a.m., indicated the tomato half should not be in the box and removed the tomato half from the box.</p> <p>Observation on 8/29/13 at 2:20 p.m., 8 out of 28 overhead ceiling light covers contained insects, 3 out of 28 overhead ceiling light covers contained water stains, and 1 out of 28 ceiling light covers had an electrical wire hanging down inside light.</p> <p>Interview with the Dietary Aide #2 on 8/29/13 at 2:22 p.m., indicated the objects in the overhead ceiling lights looked like bugs.</p> <p>Interview with the Dietary Manager on 8/29/13 at 2:30 p.m.; the Dietary Manager verified the light observations and indicated the number observed was correct.</p>		<p>lighting issues will be resolved by 10/15/13. Dietary staff will be in-serviced regarding the "Food and Safety in Receiving and Storage" policy. In-service completion date 10/10/13. Q.A. will monitor the compliance of the "Food and Safety in Receiving and Storage" policy through the use of the checklist located on the production sheets for 6 months. When the production sheets have received 6 months of 100% compliance through the Q.A. process the monthly audits will be eliminated.</p>				

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	<p>The Facility's policy for Dry Storage Guidelines revised on 8/6/12, indicated dry storage areas should be well-ventilated and pest free.</p> <p>3.1-21(i)(2)</p>			

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F000431 SS=F	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' multi dose medications being used had a</p>	F000431	F431- 1) Nurses will be in-serviced on 9/24/13 & 9/25/13 to review our "Packing and Labeling" policy including the protocol for the labeling of	09/27/2013			

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	<p>documented open date and name labels as indicated by policy and procedure 1 of 1 medication cart observed.</p> <p>Findings include:</p> <p>During observation of the medication cart on 8/28/13 at 2:00 p.m., and 8/29/13 at 8:00 a.m., the following opened multi dose medications did not have a documented open date:</p> <p>Resident #30 Nitrostat Resident #85 Nitrostat, Maalox, Resident #93 Nitrostat, Resident #94 Timolol, eye drop (unable to read label) Resident #95 senexon, docusate liquid, Lantus, HumaLog Resident #9 Tums, Maalox Resident #92 Miralax Resident #90 Maalox, Resident #10 Maalox Resident #32 Promo liquid Resident #89 Levemir Resident #27 Lantus, NovoLog Resident #10 Miralax</p> <p>The following medications were observed not to have resident(s) name(s) labels:</p> <p>Resident #90 Refresh tube Resident #30 B 12</p>		<p>prescription drugs. Initial audit of all medication carts regarding proper labeling of prescription drugs will be completed by 9/27/13. The DON will monitor the compliance of our "Packing and Labeling" policy through weekly audits of medication carts for 30 days then monthly for 6 months. The Q.A. process will monitor compliance for the following 6 months.</p>				

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	<p>Resident #91 B 12 Resident #27 Lantus, NovoLog</p> <p>During interview with LPN #2 on 8/28/13 at 2:10 p.m., indicated when asked what was wrong with the multi dose medications in the medication cart, "no open dates, didn't know it had to be on bottles as well as the cartons."</p> <p>During interview with LPN #1 on 8/29/13 at 8:30 a.m., indicated when shown Nitrostat vials in the medication cart during medication administration "no open date, nor name."</p> <p>A current facility policy received from the ADM (Administrator) on 8/29/13 at 8:30 a.m., titled "Packing and Labeling revised dates: 11/03/06." indicated "1. Prescription (legend) drugs are labeled in accordance with State law and include the appropriate accessory and cautionary in instructions and the expiration date when applicable. Labeling of prescription drugs shall include the following:  A. Resident's full name ...  F... Date of issue and expiration date ...  H. Ancillary, date opened and precautionary labels (see #6) ...</p>						

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	<p>6. Small multidose vials such as insulin, eye drops, ear drops, etc, are dispensed in amber packaging vials. ... The medication vial bottle itself will be labeled with the resident name sticker only to assist the nurse in replacing it in the accompanying packaging vial after use."</p> <p>3.1-25(k)(1)(6)</p>			

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F009999	<p>3.1-35 COMPREHENSIVE CARE PLAN</p> <p>1. (g) The services provided or arranged by the facility must:</p> <p>(2) Be provided by quality persons in accordance with each resident ' s written care plan.</p> <p>This state rule was not met by evidence by:</p> <p>Based on record review and interview, the facility failed to test a wanderguard pendant as indicated by the care plan for 1 of 5 sampled residents reviewed for the care plan. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1's clinical record was reviewed on 8/28/13 at 2:10 p.m.</p> <p>Resident #1's wandering /elopement risk review tools dated 1/16/13 and 7/6/13 (current) indicated Resident #1 was an elopement risk.</p>	F009999	F9999 – 1) Nurses will be in-serviced on 9/24/13 & 9/25/13 to review our “Resident Safety Program: Wandering and Elopement (SNF)” policy and review of the procedure for checking the functionality of each wander guard. All wander guards will be care planned for each resident then becoming the responsibility of the nurse responsible for that said resident per shift. Wander guard functionality will be checked each shift and recorded on the Medication Administration Record (MAR). DON/designee will monitor MAR's daily for 2 weeks, weekly for 30 days then monthly their after. The Q.A process will monitor compliance for the following 6 months. 2) The creation and implementation of individualized programming to use when residents are exhibiting exit seeking behaviors will be created/obtained for the use by direct care staff. Items used for individualized programming will be obtained by 10/10/13. Nursing staff will be in-serviced on the use of individualized programming as an intervention for exit seeking behaviors. In-service completion date 10/15/13. Activities Director and/or designee will monitor the effectiveness and care plans of the individualized programming items used on a case by case basis.	09/25/2013	

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	<p>Resident # 1's care plan dated 1/25/13 and remained current indicated an elopement risk plan was written. The care plan indicated wanderguards were to be checked every shift for functionality by the nurse responsible for said resident.</p> <p>Resident #1's clinical record notes indicated the resident had eloped (to leave a hospital ... without permission - Taber's Cyclopedic Medical Dictionary , Edition 22, # 2, page 734), from the facility on 8-22-2013 at 3:00 p.m. due to the resident's wanderguard pendant failed to sound.</p> <p>Interview on at 8/23/13 at 9:35 a.m., with RN #2 indicated "Sometimes the wanderguards work and sometimes they don't."</p> <p>Interview on 8/28/13 at 9:45 a.m., with the DON (Director of Nursing) indicated wanderguard pendants were checked by the comprehensive unit nurse responsible for medicine cart #1. Due to staff changes, Resident #1's pendant had not been</p>						

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	<p>checked, because _____ (genders) name had been accidentally been omitted from the list.</p> <p>3.1-45 ACCIDENTS</p> <p>2. (a) The facility must ensure the following:</p> <p>(2). Each resident receives adequate supervision and assistive devices to prevent accidents.</p> <p>This state rule was not met as evidence by:</p> <p>Based on observation, record review, and interview, the facility failed to ensure adequate supervision of a resident identified as an elopement risk for 1 of 3 residents reviewed for elopement risk. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1's clinical record was reviewed on 8/28/2013 at 2:10 p.m.</p> <p>Resident #1's wandering /elopement risk review tools dated 1/16/13 and</p>				

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	<p>7/6/13 (current) indicated Resident #1 was an elopement risk. Resident # 1's care plan dated 1/25/13 and remained current indicated an elopement risk plan was written. The care plan indicated wanderguards were to be checked every shift for functionality by the nurse responsible for said resident.</p> <p>The August 2013 Medication Administration Record (MAR), of Resident #1, indicated a wanderguard was ordered due to elopement risk.</p> <p>Review of Resident #1's nursing notes indicated, "7/13/2013 at 4:00 p.m., _____ [name Resident #1] began to exit, looking for the bus. _____ [name Resident #1] was hard to redirect ... 7/14/2013 at 5:00 p.m., ... an increase in exit seeking behavior and paranoia to medications. ... 7/16/2013 at 5:00 _____ [name Resident #1] set off</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155253	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/29/2013
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NAME OF PROVIDER OR SUPPLIER  MEADOWOOD HEALTH PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 2455 TAMARACK TR BLOOMINGTON, IN 47408
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	<p>wanderguard x (times) 1. ... 8/6/2013, [no time indicated], the same nurse later found resident #1 in another residents room. _____ [name Resident #1 had woke [gender] up after speaking very loudly to _____ [gender]. ... _____ [name Resident #1] then attempted to go in room #25. ... 8/18/2013 at 2:00 p.m., ... Wanderguard in place, ... resident has wandered into other rooms today."</p> <p>Resident #1's clinical record notes indicated the resident had eloped (to leave a hospital ... without permission - Taber's Cyclopedic Medical Dictionary , Edition 22, # 2, page 734), from the facility on 8-22-2013 at 3:00 p.m. due to the resident's wanderguard pendant failed to sound. The notes indicated, "Res [Resident #1] found in parking lot in w/c [wheelchair] with wanderguard on but had not functioned properly. DON, Administrator, and daughter were notified. No injuries to _____ [name Resident #1] were found. _____ [name Resident #1 indicated to staff that _____ [gender] was looking for horses. ... 8/22/13 at 6:00 p.m., _____ [name Resident #1] had set off wanderguard x 3 and staff redirected each time."</p>			

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	<p>On 8/29/2013 at 9:42 a.m., phone interview with LPN #3, indicated "she had seen Resident #1 in the hallway self propelling down the hallway fifteen minutes prior to the elopement. I was informed by another resident's daughter at 3:00 p.m. on 8/22/2013, that Resident #1 was outside in rear parking lot alone."</p> <p>On 8/29/2013 at 9:52 a.m., interview with CNA #1, who was assigned to Resident #1, indicated they were on lunch during the time Resident #1 eloped. Resident #1 was unsupervised. She also indicated, " They told me about the elopement after I got back from lunch."</p> <p>On 8/28/2013 at 10 a.m., Resident #1 observed in room located at the end of 200 hallway to point of elopement, at end of 100 hallway, with Resident #1 ' s son. Exit door had wanderguard sensor in place. Outside exit door is a ramp that leads to parking lot located on posterior side of building.</p> <p>Review of documentation labeled "Resident Safety Program: Wandering and Elopement (SNF)" received from the ADM (Administrator) on 8/28/13 at 10:35 a.m., indicated "... Purpose: ... To</p>				

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	<p>maximize resident 's safety through prompt investigations of attempted elopements, actual elopements or if a resident is missing. ... Provide a proactive program of supervision and interventions to minimize risk of a resident elopement. Provide a method for facility analysis of individual resident attempted /elopement incidents. ... (Wandering) is to move around aimlessly or with no apparent destination and is most often associated with various forms of dementing diseases. ... (Elopement) is when a resident, who has been determined to need supervision, or does not have permission to leave the facility, has exited the building and may experience (or has the potential) to experience heat or cold exposure, dehydration, physical and/or medical complications or injury."</p> <p>On 8/28/2013 at 9:45 a.m., the Director of Nursing (DON), indicated that before elopement of Resident #1 on 8/22/2013 at 3:00 p.m., the responsibility of the wanderguards was the responsibility of the comprehensive unit nurse on medicine cart #1. She indicated that inadvertently Resident #1 had been removed from the wanderguard list, so the wanderguard had not been checked. When Resident #1 was</p>			

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	found outside, it was noted the wanderguard had not functioned or alarmed prior to Resident #1 leaving the building unattended.				