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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/05/2012 |
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| NAME OF PROVIDER OR SUPPLIER MERIDIAN NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225 |
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| F0000 | <p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00118321.</p> <p>Complaint IN00118321 was unsubstantiated due to lack of evidence.</p> <p>Survey Dates: October 29, 30, 31 November 1, 2, 5 2012</p> <p>Facility Number: 000386 Provider Number: 155428 AIM Number: 100286820</p> <p>Survey Team: Dinah Jones, RN TC Patti Allen, BSW Marcy Smith, RN (October 29, 30 2012) Leia Alley, RN</p> <p>Census Bed Type: SNF/NF: 28 Total: 28</p> <p>Census Payor Type: Medicare: 1 Medicaid: 24 Other: 3 Total: 28</p> <p>These deficiencies reflect state findings</p> | F0000 | <p>Submission of this plan of correction does not constitute an admission by Meridian Nursing and Rehabilitation Center or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. On 11/5/12 a survey team from the Indiana State Department of Health completed an annual survey at Meridian Nursing and Rehabilitation. Please consider this plan of correction to be the facility's credible allegation of compliance. Meridian Nursing and Rehabilitation request a desk review to verify the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction of 11/30/12. Respectfully submitted Tiffany M Ross Administrator Meridian Nursing and Rehabilitation</p> | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| | <p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/14/12 Cathy Emswiller RN</p> | | | |

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| F0249 SS=C | <p>483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL</p> <p>The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.</p> <p>Based on observation, interview and record review the facility failed to ensure the activity program was directed by a qualified professional in that the facility did not have a qualified activities professional on staff nor a consultant contract to provide services between the dates of 10/17/11 and 10/31/12. This had the potential of affecting 28 of 28 residents residing in the facility.</p> <p>Findings include:</p> <p>On 10/29/12 at 10:30 AM, 10/31/12 at 10:00 AM, 11/1/12 at 2:30 PM, 11/2/12 at 11:00 AM and 11/5/12 at 10:30 AM, observations were made of the Activity Assistant implementing the scheduled</p> | F0249 | <p>F249 483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL It is the practice of Meridian Health and Rehabilitation Center to have an activities program that is directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed and registered, if applicable by the State in which practicing and is eligible for certification as a therapeutic recreation specialist or as an activity professional by a recognized accrediting body on or after October 1, 1990; or has two years experience in a social or recreational program within the last five years, 1 of which was full-time in a patient activities program in a health care setting;</p> | 11/30/2012 | |

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| | <p>activities. A large activity calendar was posted on the wall across from the Health Facility Administrator's (HFA) office and each resident's room had a copy of the current month's calendar posted on a wall in their room.</p> <p>An interview with the Health Facility Administrator (HFA), on 11/2/12, indicated the previous Activity Director's last day of work was 10/17/12. The HFA indicated a job posting was currently on the company web site and on Career Builder to fill the position.</p> <p>A review of the written plan to hire an Activity Director indicated the HFA had two interviews on 10/31/12, planned to have a person in place within 14-30 days from 11/2/12, and a contract had been initiated with a company for activity consultation. The consulting company had not spoken with the HFA or made an onsite visit concerning the over site of the activity program as of the survey exit date of 11/05/12.</p> <p>3.1-33(e) 3.1-33(e)(2) 3.1-33(e)(3) 3.1-33(e)(4)</p> | | <p>or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. I. No residents were affected by the lack of a qualified activity director. Activities continued to occur as scheduled.</p> <p>II. All residents have the potential to be affected by the lack of a qualified activity director.</p> <p>III. The facility has hired an activity director 11/14/2012. The consulting agreement has been signed and the activity consultant has provided an onsite visit. The activity director will complete the State approved training course within the next six months as required by the State. In addition, the activity calendar is being reviewed daily Monday-Friday during morning meeting to ensure activity assistance is provided if necessary. The activity calendar is reviewed on week-ends by the manager on duty. The new activity director and the activity assistant will continue to conduct programming as scheduled. IV. The Administrator will ensure that the activity director has completed the training course approved by the State. In addition, the Administrator or her designee is conducting quality improvement audits of the activity programs. A random sample of 5 activities will be audited weekly for 30 days; then monthly for 6 months to ensure activities are being conducted as scheduled.</p> | | |

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| | | | Results of all audits will be presented to the facility's quality assurance committee monthly for additional recommendations if necessary. | | |

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| F0282 SS=C | <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 observation, interview and record review the facility failed to ensure the activity program was directed by a qualified professional in that the facility did not have a qualified activities professional on staff nor a consultant contract to provide services between the dates of 10/17/11 and 10/31/12. This had the potential of affecting 1 of 1 residents reviewed for activities in a sample of 9 residents. Resident #3.</p> <p>Findings include:</p> <p>No Activity Director or Activity Consultant was observed during the survey dates of 10/29/12, 10/30/12, 10/31/12, 11/1/12, 11/2/12 and 11/5/12.</p> <p>On 10/29/12 at 10:30 AM, 10/31/12 at 10:00 AM, 11/1/12 at 2:30 PM, 11/2/12 at 11:00 AM and 11/5/12 at 10:30 AM, observations were made of the Activity Assistant implementing the scheduled activities. A large activity calendar was posted on the wall across from the Health Facility Administrator's (HFA) office.</p> | F0282 | <p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN</p> <p>It is the practice of Meridian Nursing and Rehabilitation Center to provide services by qualified persons in accordance with each resident's written plan of care.</p> <p>I. Resident #3's activity plan has been reviewed and is receiving/attending activities of interest. II. All residents have the potential to be affected by the lack of a qualified activity director.</p> <p>III. The facility has hired an activity director 11/14/2012. The consulting agreement has been signed and the activity consultant has provided an onsite visit. The activity director will complete the State approved training course within the next six months as required by the State. In addition, the activity calendar is being reviewed daily Monday-Friday during morning meeting to ensure activity assistance is provided if necessary. The week-end activities are reviewed by the manager on duty. The new activity director and the activity assistant will continue to conduct programming as scheduled. IV. The Administrator will ensure that the activity director has</p> | 11/30/2012 | |

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| | <p>An activity calendar for the month of October was observed on 10/31/12 at 2:45 PM, taped to the closet door in Resident #3's room. On 11/1/12 at 2:00 PM an activity calendar for the month of November was observed taped to the closet door in Resident #3's room.</p> <p>An interview with Resident #3 on 11/2/12 at 2:00 PM indicated he preferred to be in his room watching television and listening to his radio rather than participating in group activities. He indicated he enjoyed going outside on the back porch to smoke during the smoke breaks.</p> <p>A record review of Resident #3's Care Plan on 11/2/12 at 10:48 AM, indicated an assessment of the resident indicated he preferred listening to music, doing things with other residents, and going outside to get fresh air when the weather was good.</p> <p>A goal listed in the reviewed Care Plan indicated the resident would participate in self-directed activities daily and express satisfaction with the level of his activity involvement through the next Care Plan review of 1/13/13. Indicated approaches included providing leisure supplies as needed for his self-directed pursuits, introducing him to residents with similar interests, discuss with the resident the</p> | | <p>completed the training course approved by the State. In addition, the Administrator or her designee is conducting quality improvement audits of the activity programs. A random sample of 5 activities will be audited weekly for 30 days; then monthly for 6 months to ensure activities are being conducted as scheduled. Results of all audits will be presented to the facility's quality assurance committee monthly for additional recommendations if necessary.</p> | | |

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| | <p>importance of social interaction, inviting and assisting him to scheduled activities and considering the impact of medical problems on his activity level.</p> <p>Documentation of Resident #3's participation was signed by the Activity Assistant in the resident's clinical record.</p> <p>An interview with the Health Facility Administrator (HFA), on 11/2/12, indicated the previous Activity Director's last day of work was 10/17/12. The HFA indicated a job posting was currently on the company web site and on Career Builder to fill the position.</p> <p>A review on 11/2/12 at 2:30 PM of the written plan to hire an Activity Director indicated the HFA had conducted two interviews on 10/31/12, planned to have a person in place within 14-30 days from 11/2/12, and a contract had been initiated with [Name of Company] for activity consultation. The consulting company had not spoken with the HFA or made an onsite visit concerning the oversight of the activity program as of the survey exit date of 11/05/12.</p> <p>3.1-35(g)(1)</p> | | | |

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| F0323 SS=D | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure bed mattresses were properly fitted in that 1 of 28 resident beds observed, 1 mattress did not meet the requirements of less than 4.75 inches of space between the edge of the mattress and the half side rails which were raised. This had the potential to affect 1 of 28 residents residing in the facility. Resident #31.</p> <p>Findings Include:</p> <p>The mattress was observed on 10/19/12 at 2:30 PM in Resident #31's room. The resident was lying in bed with her eyes closed. The head of the bed was slightly elevated and the resident was lying in the center of the mattress. A measurement taken at that time indicated a gap of 6" in Zone 3 between the rail and the mattress.</p> <p>An interview with the Health Facility Administrator on 10/29/12 at 2:40 PM indicated she was aware of the potential for harm and she immediately contacted the Maintenance Consultant and the</p> | F0323 | <p>F323 483.25(h) ACCIDENTS It is the practice of Meridian Nursing and Rehabilitation Center to ensure that the resident's environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. I. Resident #31 no longer resides in the facility II. All residents were re-assessed for the use of bedrails during the survey. All bedrails in the facility were audited during the survey and were removed if found to be unnecessary or unsafe. III. The facility has a policy on bed safety and the use of bedrails. The policy was reviewed during the survey and found to be complete. Nursing personnel were re-educated on this policy and the resident assessment of bed rails during the survey. The admission and quarterly nursing assessment includes a measurement of the bedrail to ensure the gap does not exceed 4.75 inches. Maintenance personnel have been re-educated and bedrail safety has been added to the preventive maintenance checklist. Any bed rail that does</p> | 11/30/2012 | |

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| | <p>facility Maintenance Director, who were in the building.</p> <p>The Maintenance Consultant and facility Maintenance Director were observed replacing the mattress in Resident #31's room at 3:00 PM.</p> <p>Measurements were repeated at 3:15 PM of Zone 3 of the resident's mattress and half side rails with a result of less than one inch.</p> <p>A Policy Statement entitled, "Bed Safety", on 10/30/12 at 3:00 PM indicated, "Our facility shall provide a safe sleeping environment for the resident. Point #2 of the facility's "Policy Interpretation and Implementation" indicated, "To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard and bed assessor), the facility shall promote the following approaches:</p> <ul style="list-style-type: none"> a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; b. Review that gaps within the bed system are within the dimensions established by the FDA; c. Ensure that when bed system | | <p>not meet the safety requirements will be removed. IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure that bedrails are utilized only if necessary and that any bedrails in use are safe. Residents who utilize bedrails are reviewed weekly for 30 days; then quarterly ongoing. In addition, the maintenance director or his designee is reviewing bedrails monthly ongoing. Results of all audits will be presented to the facility's quality assurance committee monthly for additional recommendations if necessary.</p> | | | | |

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| | <p>components are worn and need to be replaced, components meet manufacturer specifications;</p> <p>d. Ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit...;</p> <p>e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.)</p> <p>On 10/30/12 at 11:00 AM, a record review of Resident # 31's Quarterly Minimum Data Set Assessment dated 6/20/12 indicated a Brief Interview for Mental Status score of 5/15 indicating severe mental impairment. Her active diagnoses included but were not limited to: Alzheimer's Disease, Seizure Disorder and Psychotic Disorder.</p> <p>A review of the facility's Compliance Training Attendance Log on 10/30/12 at 3:00 PM, indicated mandatory inservices of all staff entitled, "Proper Placement of Bed Rails, Proper Spacing Between Rail and Mattress, were conducted on 10/29/12 and 10/30/12.</p> <p>3.1-19(c)</p> | | | | | | |

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| F0441 SS=E | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview the facility failed to ensure a residents</p> | F0441 | F441 483.65 (a)(1) INFECTION CONTROL It is the practice of | 11/30/2012 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155428 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/05/2012 |
| NAME OF PROVIDER OR SUPPLIER MERIDIAN NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2102 S MERIDIAN ST INDIANAPOLIS, IN 46225 | | |
| (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>were tested for tuberculosis annually and prior to admission to the facility for 5 of 5 residents reviewed for tuberculosis testing in a sample of 28. (Residents #7, 16, 26, 6 and 12)</p> <p>Findings include:</p> <p>1. The record of Resident #7 was reviewed on 10/30/12 at 11:15 p.m. He was admitted to the facility on 2/7/2003.</p> <p>A Resident Immunization Record for Resident #7 indicated his last Mantoux test (a skin test for tuberculosis) was done on 7/12/11.</p> <p>2. The record of Resident #16 was reviewed on 10/29/12 at 12:55 p.m. She was admitted to the facility on 7/2/12.</p> <p>A Resident Immunization Record for Resident #16 indicated she had not received either the 1st or 2nd step Mantoux test.</p> <p>3. The record of Resident #26 was reviewed on 10/29/12 at 1:05 p.m. She was admitted to the facility on 7/21/11.</p> <p>A Resident Immunization Record for Resident #26 indicated her last</p> | | <p>Meridian Nursing & Rehabilitation Center to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. I. Residents #7, #16, #26, and #6 received the annual tuberculin skin test on 10/30/2012. II. All clinical records were audited on 10/30/2012 to determine if any other resident was lacking annual tuberculin skin testing. Any resident who did not have an annual TB skin test was completed on 10/31/2012. III. The facility policy was reviewed and amended to include annual TB testing to be completed on all residents yearly in April. Licensed nurses have been re-educated regarding the need to administer TB skin testing within 3 months prior to or upon admission to the facility and on the revisions to the policy. Inservice education is also being scheduled to provide certification training to licensed nurses on administering the PPD Mantoux intradermal tuberculin skin testing, reading, and results. IV. The Director of Nursing Services or her designee is conducting quality improvement audits of tuberculin skin testing. A random sample of 5 resident records will be reviewed monthly ongoing. In addition, all new admissions will be reviewed during daily</p> | | |

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| | <p>Mantoux test was done on 8/4/11.</p> <p>4. The record of Resident #6 was reviewed on 10/30/12 at 9:30 a.m. She was admitted to the facility on 1/15/03.</p> <p>A Resident Immunization Record for Resident #6 indicated her last Mantoux test was done on 9/10/10.</p> <p>5. The record of Resident #12 was reviewed on 10/30/12 at 9:20 a.m. He was admitted to the facility on 7/18/12.</p> <p>A Resident Immunization Record for Resident #12 indicated his last Mantoux test was done on 7/22/12.</p> <p>An undated facility policy, received from the Director of Nursing (DON) on 10/30/12 at 3:00 p.m., titled "Tuberculosis, Screening Residents for," indicated "...b. A tuberculin skin test shall be completed within three months prior to admission or upon admission and read eight to seventy two hours. The results will be recorded in millimeters of induration with the date given, date read, and by whom administered and read. c. As part of our infection control program, residents will receive annual tuberculin skin testing in the month of</p> | | interdisciplinary team meeting to ensure that the tuberculin skin testing was completed. Results of all audits will be presented to the facility's quality assurance committee monthly for additional recommendations if necessary. | | |

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| | <p>April. d. For residents who have not had a documented negative skin test result during the preceding 12 months the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within 1-3 weeks after the first test...4. Serial Testing of Residents: a. The facility will conduct an annual tuberculin skin test on all residents with a history of negative results..."</p> <p>During an interview with the DON on 10/30/12 at 3:15 p.m. she indicated she was not able to provide any further information regarding why Residents #7, 16, 26, 6 and 12 did not receive their tuberculin skin testing on admission or annually, according to facility policy.</p> <p>3.1-18(j)</p> | | | |