

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 03/14/2014
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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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F000000	<p>This survey was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint Number IN00144763.</p> <p>Complaint IN00144763 unsubstantiated due to lack of sufficient evidence.</p> <p>Survey Dates: March 10, 11, 12, 13 and 14, 2014.</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Survey team: Toni Maley, BSW, TC Karen Koeberlein, RN Tina Smith Staats, RN Ginger McNamee, RN (3/11/14, 3/12/14, 3/14/14) Karen Lewis, RN (3/12/14, 3/13/14, 3/14/14)</p> <p>Census bed type: SNF: 8 SNF/NF: 50 Total: 58</p> <p>Census payor type: Medicare: 8 Medicaid: 47</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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F000244 SS=E	<p>Other: 3 Total: 58</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2 Quality review completed by Debora Barth, RN.</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on observation, interview and record review, the facility failed to ensure resident grievances regarding dissatisfaction with food quality for 7 of 15 residents interviewed regarding food quality (Resident #63, #17, #58, #52, #4, #21 and #8).</p> <p>Findings include:</p> <p>During a 3/10/14, 11:08 a.m. interview, Resident #63 indicated "This is the worse food I have ever had..."</p> <p>During a 3/11/14, 9:31 a.m., interview, Resident #58 indicated</p>	F000244	<p>1. Resident #s 63, 17, 58, 52, 4, 21 and 8 incurred no negative outcome.</p> <p>2. All residents have the potential to be affected. Grievances voiced through resident council during the past 12 months have again been reviewed to confirm that said grievances have been addressed.</p> <p>3. The policy and procedure for Grievances has been reviewed and no revisions were made. (See Attachment # A-1) Administrative staff have been re-educated on the policy and procedure.</p> <p>4. The Administrator or her</p>	04/01/2014	

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	<p>the facility menu repeated items such as waxed beans and mixed vegetables frequently and lacked variety. "Supper is always cold and milk is not cold enough."</p> <p>During 3/10/14, 11:35 a.m., interview, Resident #4 indicated the food was often cold.</p> <p>During a 3/11/14, 2:34 p.m., interview, Resident #8 indicated the food was "slop" and not good. Food was overcooked or undercooked almost every meal.</p> <p>During a 3/11/14, 9:37 a.m., interview, Resident #17 indicated the food was either over cooked or undercooked daily and the facility used too much garlic when cooking.</p> <p>During a 3/10/14, 11:51 a.m., interview, Resident #52 indicated the meats were tough and tasteless and the bacon was usually burnt. Lunch and dinner were usually cold.</p> <p>During a 3/10/13, 11:08 a.m., interview, Resident #21 indicated the food wasn't warm.</p> <p>During a 3/10/14, 12:00 to 12:45 p.m., meal observation in the 500/600 Skilled Dining Room,</p>		<p>designee will monitor grievances to ensure concerns voiced are investigated, addressed in a timely and appropriate manner, as well as ensuring corrective action has been initiated and follow up monitoring assigned to assess compliance daily on scheduled days of work. (See Attachment# A-2) Should concerns be observed, re-education will be provided. The grievance process, including review of grievances and corrective actions taken, will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.</p>		

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	<p>Resident #41 was served a slice of lasagna which was black on top. The resident stated "this is burnt." She took a bite and said "this is hard and burnt."</p> <p>Review of the current facility policy, dated 6/2006, titled "GRIEVANCE POLICY," provided by the Administrator on 3/14/14 at 12:15 p.m., included, but was not limited to, the following:</p> <p>"Policy: It is the policy of this facility to ensure resident, family and staff concerns are recognized and addressed by the facility management in a thorough and timely manner....</p> <p>...3. A copy of the concern should be forwarded to the appropriate department head for continued investigation....</p> <p>...4. Upon completion of the investigation, the department head should review the findings of the investigation with the administrator and the proposed corrective action...."</p> <p>3.1-3(l)</p> <p>Review of the Resident Council Meeting</p>			

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	<p>Minutes for 12/13/13, 1/9/14 and 2/10/14 indicated recurrent resident dissatisfaction with Dietary Services.</p> <p>Resident Council Meeting Minutes for 1/9/14 indicated residents voiced concerns about lack of variety in the menu, "Too much hamburger aeb [as evidenced by] Swiss Steak and Cube Steak isn't real, it's hamburger".</p> <p>Resident Council Meeting Minutes, dated 2/10/14, indicated New Business for the month residents voiced concerns related to the lack of variety in the menu, "Resident would like more of a variety instead of the same things". The facility response to the concern was "Corporate creates menus not dietary staff, so we can only make whats [sic] written for us".</p> <p>During an interview on 3/14/14 at 12:38 p.m., with the Dietary Manager and the Administrator, the process for resolving resident grievances from Resident Council were reviewed. The Administrator indicated the residents voice their concerns to the Activity Director at the meetings. These concerns are written in the minutes and given to the appropriate Department Heads. The Department Heads address the concerns and send a written</p>						

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F000309 SS=D	<p>department response to the Resident Council through the Activity Director. The Administrator indicated that if the concerns required immediate action, the Department Head would go directly to the complainant and address the resolution.</p> <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>Based on observation, interview, and record review, the facility failed to ensure a resident with a scheduled dressing change, received the dressing change in accordance with physician's orders. This practice affected 1 of 1 resident reviewed for changes of PICC line dressings (Resident #78).</p> <p>Findings include:</p> <p>The clinical record for Resident #78 was reviewed on 3/12/14 at 2:40 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and squamous cell carcinoma. Resident #78 had a physician ordered dressing change with an</p>	F000309	<p>1. Resident #78 incurred no negative outcome. Resident #78 dressing was changed as soon as it was brought to the facility's attention.</p> <p>2. All residents who have PICC line dressings have the potential to be affected. All residents who have ordered PICC line dressings have been reviewed to ensure the dressings have been changed in accordance to their physician orders.</p> <p>3. The policy and procedure for PICC lines has been reviewed and no changes were made. (See Attachment #B-1) All nurses have been re-educated on the policy and procedure.</p>	04/01/2014			

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	<p>original start date of 2/19/14. The order read "change picc line dressing every 7 days and PRN (as needed) for drainage and soilage."</p> <p>During an observation on 3/11/14 at 2:00 p.m., Resident #78 had a peripherally inserted central catheter line (PICC line) on the left arm with a date of 3/3/14. The dressing tape was loose, and beginning to fall off.</p> <p>During an additional observation on 3/12/14 at 2:00 p.m., Resident #78 was lying in bed with the left arm visible. The dressing on Resident #78's left arm had a date of 3/3/14.</p> <p>During an interview on 3/12/14 at 2:07 p.m., LPN #1 indicated the dressing was ordered to be changed every 7 days. LPN #1 also indicated according to physician orders, the dressing should have been changed on 3/10/14.</p> <p>During an interview on 3/12/14 at 2:12 p.m., the corporate nurse consultant indicated there was no policy available in regard to completing timely dressing changes on residents with picc lines.</p> <p>3.1-37(a)</p>		<p>4. The DON or her designee will conduct observations to ensure PICC line dressings are changed on all residents with PICC lines, as ordered, on scheduled days of workdaily for 2 weeks, three times a week for 2 weeks, two times a week for 4 weeks and then weekly until compliance is maintained for 6 consecutive months. (See Attachment #B-2) Should non-compliance be observed re-education shall be provided. The 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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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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 the medication carts were locked when not in use for 2 of 3</p>	F000431	1.Resident #s 41, 78, 76, 23, 32, 13, 25, 39 ,59,10, 63, 44, 58, 52, 17, 8, 40, 66, 5, 46, 57,6, 24, 47, 38, 37, 53, and 4 incurred no negativeoutcomes. Medication	04/01/2014			

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	<p>medication carts observed (500/600 medication cart and 100/200 medication cart). This deficient practice failed to provide secured limited access for 28 residents. (Resident #'s 41, 78, 76, 23, 32, 13, 25, 39, 59, 10, 63, 44, 58, 52, 17, 8, 40, 66, 5, 46, 57, 6, 24, 47, 38, 37, 53, and 4) This deficient practice also allowed narcotics and drugs at risk for abuse to not be double locked for Resident #'s 41, 78, 76, 23, 32, 13, 25, 59, 63, 58, 17, 8, 6, 24, 47, and 4.</p> <p>Findings include:</p> <p>1.) On 3/11/14 at 1:07 p.m., the 500/600 hall medication cart was observed parked on the 600 hall unlocked with no nurse or QMA attending it. This was a common hallway used by residents, staff and visitors. LPN #1 returned to the cart and indicated she had been in a resident's room giving medications. She indicated she could not see the medication cart while in the resident's room. She indicated she should have locked the medication cart before leaving it.</p> <p>2.) A list of residents with medications stored on the 500/600 medication cart was provided by the</p>		<p>carts on the 100/200 hall and 500/600 hall were observed and are properly secured.</p> <p>2. All residents who have medication stored in the facility have the potential to be affected. All medication carts were observed and are properly secured.</p> <p>3. The policy and procedure for medication storage has been reviewed and no revisions were made. (See Attachment #C-1) The nurses have been re-educated on the policy and procedure.</p> <p>4. The DON or her designee will conduct observations of all medication carts to ensure that the medications are properly secured daily on scheduled days for 2 weeks, three times a week for 2 weeks, two times a week for 4 weeks then weekly until compliance is maintained for 6 consecutive months. (See Attachment #C-2) Should concerns be noted re-education will be provided. The results of said observation will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>				

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	<p>Corporate Nurse Consultant on 3/14/14 at 1:00 p.m. The list indicated Resident #'s 41, 78, 76, 23, 32, 13, 25, 39, 59, 10, 63, 44, 58, and 52 all had medications on the 500/600 medication cart when it was observed unlocked. Ten of the residents' medications included Schedule II or III narcotics or other drugs with the potential for abuse and needed to be double locked. The list indicated the cart had contained the following residents' medications that were to be double locked:</p> <p>Resident #78 had 52 tablets of morphine sulfate IR 15 mg and 30 tablets of oxycodone APAP 5/325 mg.</p> <p>Resident #76 had 30 tablets of hydrocodone APAP 10/325 mg.</p> <p>Resident #41 had 39 tablets of alprazolam 1 mg and 30 mg oxycodone APAP 7.5/325 mg.</p> <p>Resident #23 had 30 tablets of oxycodone APAP 10/325 mg .</p> <p>Resident #58 had 45 tablets of lorazepam 0.5 mg, 34 tablets of zolpidem 10 mg, and 49 tablets of hydrocodone APAP 5/325 mg.</p> <p>Resident #32 had 48 tablets of clonazepam 2 mg and 19 tablets of temazepam.</p> <p>Resident #13 had 33 tablets of alprazolam, 56 tablets of oxycodone</p>			

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	<p>APAP 2.5/325 mg, and 35 tablets of oxycodone APAP 5/325 mg. Resident #25 had 46 tablets of hydrocodone APAP 5/325 mg. Resident #59 had 78 tablets of hydrocodone APAP 10/325 mg. Resident #63 had 26 tablets of alprazolam 0.25 mg and 23 tablets of oxycodone 5 mg.</p> <p>3.) During an observation on 3/14/13 at 7:22 a.m., the 100/200 hall medication cart was observed unlocked with keys on top of the cart. The medication cart was in the hallway between the two dining areas and was unattended. This common hallway was used by staff, residents, and visitors. LPN #2 approached the medication cart and indicated she should have locked the medication cart when she left the cart unattended.</p> <p>4.) A list of residents with medications stored on the 100/200 hall medication cart was provided by the Corporate Nurse Consultant on 3/14/14 at 1:00 p.m. The list indicated Residents #17, #8, #40, #66, #5, #46, #57, #6, #24, #47, #38, #37, #53, and #4 all had medications on the 100/200 medication cart when it was observed unlocked. Six of the residents with medications stored on</p>			

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	<p>the 100/200 hall medication cart had Schedule II drugs and other drugs subject to abuse stored. These medications were to be double locked:</p> <p>Resident #17 had 12 tablets of hydrocodone 10-325 milligrams (mg) and 10 tablets of alprazolam 1 mg. Resident #8 had 57 tablets of hydrocodone 5-325 mg and 28.5 milliliters (ml) of oxyfast concentrate 20 mg/1 ml. Resident #6 had 56 tablets of lorazepam 0.5 mg. Resident #24 had 35 tablets of hydrocodone 5-325 mg and 29 tablets of lyrica 50 mg. Resident #47 had 60 tablets of clonazepam 0.5 mg and 19 tablets of hydrocodone 5-325 mg. Resident #4 had 60 tablets of diazepam 5 mg, 29 tablets of hydrocodone 5-325 mg and 34 tablets of lyrica 100 mg.</p> <p>During an interview with LPN #3 on 3/14/14 at 8:55 a.m., she indicated the medication carts are to be locked anytime they are unattended.</p> <p>During an interview with the Administrator on 3/14/14 at 10:47 a.m., she indicated a medication cart should never be left unlocked</p>				

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	<p>and unattended.</p> <p>5.) Review of the current facility policy, dated 8/2010, titled "MEDICATION ADMINISTRATION POLICY AND PROCEDURE," provided by the Corporate Nurse Consultant on 3/14/14 at 9:00 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To administer medications according to the guidelines set forth by the State and Federal regulations....</p> <p>...5. Medication carts and storage rooms will remain locked when unattended....</p> <p>...33. Med room and med carts must stay locked when unattended....</p> <p>...36. Once narcotic count has been completed, the nurse on duty is responsible for his/her medication cart. No other facility or non-facility personnel are to be allowed unsupervised access to the medication carts, except for pharmacy technicians....</p> <p>...37. All Schedule II narcotics are kept under double locks, per facility policy...."</p> <p>Review of the current facility, undated policy, titled "STORING</p>				

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	<p>DRUGS," provided by the Administrator on 3/14/14 at 12:15 p.m., included, but was not limited to, the following:</p> <p>"Policy Drugs and biologicals will be stored in a safe, secured, and orderly manner at proper temperatures and accessible only to licensed nursing and pharmacy personnel or staff members lawfully authorized to administer medications.... ...3. When not attended by a person permitted access, all drug storage areas and devices must be kept locked.... ...8. Controlled drugs in Schedule II (C-II) are subject to special storage.... ...C-II must be stored under double-lock..."</p> <p>3.1-25(n)</p>			
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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 03/14/2014
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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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed</p>	F000441	1.Resident #32 incurred no negative outcome. Resident#32	04/01/2014	

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	<p>to ensure proper infection control practices were followed when discarding supplies used during resident wound care. This practice had the potential to affect 1 of 1 residents residing in the facility with physician ordered wound care (Resident #32).</p> <p>Findings include:</p> <p>During an observation on 3/13/14 at 10:59 a.m., Resident #32 was sitting in her wheel chair in her room. Upon observation of Resident #32's room, a large piece of blood soaked gauze was found lying on the floor near Resident #32's bed. Resident #32 indicated she had received wound care earlier in the day.</p> <p>During further observation of Resident #32's room on 3/13/14, the trash can was found to be full and overflowing. The trash bag contained the old dressing, visibly blood soaked gauze, tape, and other supplies which had been used during Resident #32's wound care.</p> <p>During an interview on 3/13/14 at 11:00 a.m., LPN #1 was asked when Resident #32 had last received wound care. LPN #1 indicated it had been 30 minutes previously to</p>		<p>floor was cleaned with the appropriate solution. Resident #32 has since discharged from the facility.</p> <p>2.All residents who have wound care have the potential to be affected. All residents who have ordered dressing changes have been reviewed to ensure all soiled dressings were disposed of in accordance with the policy and procedure.</p> <p>3.The policy and procedure for General Instruction for Resident Care was reviewed and no revisions were made. (See Attachment #D-1) Nursing staff has been re-educated on the policy and procedure.</p> <p>4.The DON or her designee will conduct observation of wound care on one resident to ensure that all items are disposed of in accordance to the policy and procedure daily on scheduled days of work daily for 2 weeks, three times a week for 2 weeks, two times a week for 4 weeks then weekly until compliance is maintained for 6 consecutive months. (See Attachment #D-2). Should concerns be noted re-education will be provided. The results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as</p>				

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	<p>the present time. LPN #1 was shown the bloody gauze on the floor, and asked what she usually did with supplies used during wound care. LPN #1 indicated she usually threw the used supplies in the trash can after use, but had missed the trash can when she discarded the gauze. LPN #1 indicated the gauze had been used to clean Resident #32's wound. LPN #1 then picked up the blood soaked gauze from the floor, and threw it in the trash can. LPN #1 did not wipe the area of the floor where the blood soaked gauze had been lying. LPN #1 then left Resident #32's room.</p> <p>A policy provided by the Corporate Nurse Consultant on 3/14/14 at 9:30 a.m., titled "General Instructions for Resident Care" stated:</p> <p>"10. Blood spills shall be cleaned promptly with appropriate solution... 11. Disposable items must be enclosed in plastic bags for disposal."</p> <p>3.1-18(j)</p>		warranted.		