

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
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F000000	<p>This visit was for a Recertification and State Licensure survey. This visit was also for the Investigation of Complaint IN00123454.</p> <p>Complaint IN00123454 - Substantiated - Federal/State deficiencies related to the allegations were cited at F157, F206, F250, F280, and F507.</p> <p>Survey dates: April 30, May 1, 2, 6, 7, 8, and 9, 2013</p> <p>Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800</p> <p>Survey Team: Gloria J. Reisert MSW, TC Gwen Pumphrey RN Deb Peyton RN (4/30, 5/1, and 5/2/13)</p> <p>Census Bed Type: SNF: 02 SNF/NF: 79 Total: 81</p> <p>Census Payor Type: Medicare: 12 Medicaid: 63 Other: 6</p>	F000000	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."We are requesting a desk review for our revisit.	

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>Total: 81</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 5/17/13 by Suzanne Williams, RN</p>			
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F000156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to provide the "General Notice of Medicare Non-Coverage" to 2 of 3 Medicare A residents reviewed, upon discharge to home although Medicare benefit days were still available. (Residents #25 and 89)</p> <p>Findings include:</p> <p>During the review of the liability notices of 3 residents who had been discharged from Medicare in the last 6 months on 5/6/13 at 9:30 a.m., Residents #25 and 89's files were missing the Notice of Medicare Non-Coverage upon discharge from the facility.</p> <p>During an interview on 5/6/13 at 10:00 a.m. with the Business Office Manager [BOM], she indicated Residents #25 and 89 were discharged to home and that no Medicare letter was required and no other letter of non-coverage had been given either. She indicate "We really didn't discharge them - they chose to go home even though they had days left. I spoke to our other facilities and they said it just wasn't in our policy to issue any type of letter."</p>	F000156	We respectfully request an IDR due to both cited residents #25 and #89 receiving skilled therapy until the day of their discharge. Exhibit 1 is a copy of the Medicare Denial of Benefits Notice which clearly states that the notice is "to be completed by Medicare-certified facilities only upon admission/readmission or when discharging a resident off of Medicare because the level of care requirement (daily skilled care) is not met." Exhibits #2 and #6 show OT/PT minutes received for both cited residents up to the day of discharge. Exhibits #3 and #7 show physician orders for 4 wks PT/OT which would have ended after both resident's date of discharge. Exhibits #4, 5, 8 and 9 show certifications completed by both Occupational and Physical Therapy clearly stating goal dates beyond resident's date of discharge. In both cases, family and resident choose to go home with family support even though they were still receiving skilled services. The facility did not issue a Medicare Denial of Benefits Notice because the residents were still meeting level of care requirements (daily skilled care) and the facility did not determine Medicare would not cover the skilled services the resident was receiving. Per the 1/9/09 CMS memo (Exhibit 10) the SNF would	06/06/2013			

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	<p>On 5/6/13 at 1:50 p.m., the BOM presented a copy of the facility's current "Clinical Reimbursement Manual" which included, but was not limited to: "SNF [Skilled Nursing Facility] Termination Notice Matrix: 5. Part A Coverage will end because: Facility determines the beneficiary no longer requires daily skilled services. Beneficiary is discharged from facility. = ED [Expedited Determination] Notice is given - consists of a General Notice of Medicare Non-Coverage."</p> <p>3.1-4(l)(1)</p>		<p>only provide notice should the SNF believe that Medicare will not pay for the resident's skilled nursing or specialized rehabilitative services and this was not the case for either resident #25 or #89. Resident's 25 and 89 no longer reside in the facility. Social Services will issue general Notice of Medicare Non-Coverage to the resident/responsible party prior to date of discharge. The Social Services Director and Assistant will receive re-education on ensuring Medicare A residents receive a Notice of Medicare Non-Coverage prior to discharge. The Business Office Manager/Designee will complete a monthly audit discharged Medicare A residents to ensure a Notice of Medicare Non-Coverage was issued prior to discharge. The audits will be completed monthly for 6 months, and then quarterly for 2 quarters. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two months. Any further action will be as determined by the QPI committee. Date of compliance June 6, 2013.</p>		

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F000157 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 notify the residents' family/responsible party of lab results when received and when a resident was referred to</p>	F000157	Resident E was listed in the complaint sample. The facility was not given Resident E's name. A one time audit of the current resident population for the past 30 days has been completed to	06/06/2013

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	<p>therapy for additional treatment when a wound continued to not heal. This deficient practice affected 1 of 3 residents reviewed for Notification. (Resident # E)</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #E on 5/9/13 at 2:48 p.m., indicated the resident had diagnoses which included, but were not limited to: hypertension, coronary artery disease, congestive heart failure, diabetes mellitus type 1, generalized weakness, and chronic urinary tract infection.</p> <p>On 4/1/13, new physician [MD] order for a CMP [comprehensive metabolic profile] every 6 months was received. On 4/19/13, the lab was drawn which indicated resident's BUN [a test to see if the resident might be dehydrated] was high at 57. Documentation was present of the MD having been notified with no new orders received, but not the family.</p> <p>A 5/6/13 3 p.m. nurses note indicated "communication to therapy for non-healing Stage 2 to Left Buttock." Documentation was lacking of the family having been notified of the Left buttock Stage 2 wound not healing</p>		<p>ensure resident and family notification has been completed. Licensed Nurses will be re-educated on the Notification of Resident Change in Condition policy. Licensed Nursing Staff will be responsible to ensure family notification occurred and is documented in the resident's medical record. The DON/designee will complete a monthly audit of 10% of the current resident population to ensure family notification is documented in resident's medical record monthly for 6 months, and then quarterly for 2 quarters. Any identified concern will be immediately addressed, 1:1 re-education completed. Continued non-compliance will result in disciplinary action, up to and including termination, as per policy. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two months. Any further action will be as determined by the QPI committee. Date of compliance June 6, 2013.</p>				

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	<p>and that the issue was being referred to therapy for evaluation and possible treatment.</p> <p>During an interview with LPN #2 on 5/9/13 at 3:29 p.m., she indicated "resident was already on case load but we just needed them to know about the area to see if there was anything they could do."</p> <p>On 5/9/13 at 9:10 a.m., the DoN presented a copy of the facility's current policy titled "Notification of Resident Change in Condition". Review of this policy at this time included, but was not limited to: "Policy:...If the change in the resident's condition is not crucial or significant, the resident's...family or legal representative will be notified at the earliest convenient time during regular business hours. Procedure: 1. Notify the...family or legal representative at the earliest possible time, during waking hours, if there is a non-critical change in condition...3. Document in the Nurses Notes the times notification was made and the names of the person(s) to whom you spoke. Sign the entry..."</p> <p>This Federal tag is related to Complaint IN00123454.</p>				

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	3.1-5(a)(3)			

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F000206 SS=D	<p>483.12(b)(3) POLICY TO PERMIT READMISSION BEYOND BED-HOLD</p> <p>A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services.</p> <p>Based on record review and interview, the facility failed to offer the resident's responsible party the opportunity to hold the resident's bed in anticipation of return after the facility 10 day bedhold expired. This deficient practice affected 1 of 1 resident reviewed for a bedhold while hospitalized. (Resident #A)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #A on 5/7/13 at 2:35 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia with severe behavior disturbance, anxiety, psychosis, depression and schizoaffective disorder - bipolar type.</p> <p>During an interview with the the responsible party on 5/2/13 at 1:34 p.m., she indicated the resident had been sent to the hospital on 1/5/13</p>	F000206	Resident A was listed in the complaint sample. The facility was not given Resident A's name. Managers and Licensed Nursing staff will be re-educated on the facilities bed hold policy. The Administrator/Designee will complete an audit of residents that discharged due to hospitalization or therapeutic leave, weekly for 8 weeks, monthly for 4 months, and then quarterly for 2 quarters, to ensure compliance with the bed hold policy. Any identified concern will be immediately addressed, 1:1 re-education completed. Continued non-compliance will result in disciplinary action, up to and including termination, as per policy. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two months. Any further action will be as determined by the QPI committee. Date of compliance June 6, 2013.	06/06/2013	

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	<p>and the bed was to be held by the facility for about 10 days. She indicated that she had told the facility that if necessary, she would even agree to pay privately to continue to hold the bed for the resident's return.</p> <p>On 1/25/13, the responsible party was notified of the resident not being accepted back at the facility and was told to come pack up the resident's belongings. The responsible party indicated that when the family got there, the resident's belongings had already been packed up and put into a storage room and someone had already been placed in the resident's bed. She indicated she had never been contacted that the resident's bed hold had expired nor was she asked if she wanted to continue holding the bed privately.</p> <p>On 5/6/13 at 12:20 p.m., the Business Office Manager presented a copy of the facility's current policy titled "Bed Hold Policy - Medicaid residents". Review of this policy at this time included, but was not limited to: "A vacant bed may be held for you while you are in the hospital or on therapeutic leave..The State of Indiana Medicaid program does not pay for a bed hold for hospitalization and therapeutic leaves. the Center</p>				

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	<p>will provide 10 days... for hospital leaves at no charge. You may elect to pay for a bed hold after the 10th day of leave for an additional 20 days..."</p> <p>During an interview with the Business Officer Manager on 5/8/13 at 11:00 a.m., she indicated she had not contacted the responsible party to see if they wanted to continue holding the resident's bed for her return and that she thought Social Worker #1 had made the call.</p> <p>During an interview with Social Worker #1 on 5/8/13 at 1:10 p.m., she indicated she had not made the call to the family to see if they wanted to continue holding the resident's bed.</p> <p>During an interview with Social Worker #2 on 5/8/13 at 3:00 p.m., she also indicated she had not made a call to the family to see if they wanted to continue holding the resident's bed for her return. She indicated she thought someone else did.</p> <p>This Federal tag is related to Complaint IN00123454.</p> <p>3.1-12(a)(27)(A) 3.1-12(a)(27)(B)</p>						

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F000248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide individualized activities based on residents' interests. This deficient practice affected 4 of 35 residents reviewed for individualized activities. (Residents #42, #44, #59, #94)</p> <p>Findings include:</p> <p>1. During observations made on 4/30/13, 5/1/13, 5/2/13, 5/6/13, 5/7/13, and 5/9/13, Resident #59 was found to be sitting quietly in a recliner alone in her room holding a baby doll. Resident#59 was only observed leaving room for lunch daily. Staff interacted only to provide care.</p> <p>Review of the clinical record on 5/1/2013 at 11:28 a.m. included a care plan for activities which indicated resident enjoyed individualized activities.</p> <p>A family interview on 5/2/13 at 10:05 a.m. indicated Resident #59 loves</p>	F000248	Resident #42, 44, 59, and 94 have been re-interviewed for activities that meet their interests and care plans were updated as needed. The Activities Director/Designee will conduct a one time interview of current residents for their activities of interest and update care plans as needed. Activity staff have been re-educated on providing an on-going activities program for residents' interest, or providing 1:1 activities as needed. Residents not preferring to participate in group activities will have one-to-one visits at a minimum of twice weekly. Managers will complete 10% current resident population random interviews, weekly for 12 weeks, monthly for 6 months, and then quarterly for 1 quarter, to ensure current activity interests are being met. Resident's that are noted to have a negative response will be documented on a facility concern form and will require follow up from the Life Enrichment Director. Any identified concern will be immediately addressed, 1:1 re-education completed.	06/06/2013	

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	<p>music. Family reported speaking to staff regarding getting a radio in the room for Resident #59 but to date the resident still had no radio in the room. During an interview on 5/7/13 at 9:54 a.m., Resident #59 confirmed an interest in music.</p> <p>An interview with the Activities Director (AD) on 5/9/13 at 3:00 p.m. indicated being familiar with Resident #59's interests. AD reported Resident #59 does not attend many group activities except when singing groups visit the facility on weekends. AD confirmed Resident #59 enjoys music and prefers individualized activities. AD confirmed putting a radio in the resident's room is a request the facility could accommodate.</p> <p>2. During observations made on 4/30/13, 5/1/13, 5/2/13, 5/6/13, 5/7/13, and 5/9/13, Resident #94 was found to be in room watching television.</p> <p>A review of the clinical record on 5/6/13 at 11:30 a.m.. indicated resident has a known medical history including, but not limited to, multiple sclerosis, neurogenic bladder, acute renal failure, anxiety, and depression.</p> <p>During an interview on 5/2/13 at 1:10</p>		Continued non-compliance will result in disciplinary action, up to and including termination, as per policy. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two months. Any further action will be as determined by the QPI committee. Date of compliance June 6, 2013.				

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	<p>p.m., Resident #94 indicated activities do not meet her interests. Resident #94 would like to play cards and trivia games, and reported the activities offered are for older residents.</p> <p>An interview with the AD on 5/9/13 at 3:00 p.m. indicated Resident #94 does not attend many group activities and was unable to identify individualized activities specific to Resident #94's interests.</p> <p>The clinical record indicated Resident #94 prefers individualized activities but documentation was lacking as to what activities were provided by the facility.</p> <p>3. During observations made on 4/30/13, 5/1/13, 5/2/13, 5/6/13, 5/7/13, 5/8/13, and 5/9/13, Resident #44 found to be alone in her room. Resident #44's television was observed to be off each day and headphones within reach at the bedside.</p> <p>Review of the clinical record indicated Resident #44 had a known medical history including, but not limited to, cataracts, glaucoma, dementia, and delusions.</p> <p>During an interview on 4/30/13 at 11:27 a.m., Resident #44 indicated</p>				

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	<p>she lays in the bed throughout the day because she can't walk and she is "blind". Resident #44 indicated the activities do not meet her interests and when she requests staff to stay and visit with her, they tell her they don't have time.</p> <p>An interview with CNA #1 on 4/30/13 at 11:27 a.m., indicated Resident #44 requests one-on-one time with staff and often they are unavailable to meet that request due to the demands of the other residents.</p> <p>An interview with the Social Services Director (SSD) on 5/9/13 at 11:21 a.m. indicated Resident #44 does not have frequent visitors.</p> <p>An interview with the AD on 5/9/13 at 3:00 p.m.. indicated Resident #44 does not prefer group activities. The AD indicated the resident enjoys one-on-one time with staff. When asked how the facility has been able to accommodate Resident #44's request, the AD indicated the resident was not alone because the resident has a roommate. During the above observations of the resident, the roommate was not in the room.</p> <p>4. An interview Resident #42 indicated activities do not meet his</p>				

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	<p>interests and he does not wish to participate in group activities. The resident was observed on 4/30/13, 5/1/13, 5/6/13, 5/7/13, 5/8/13, and 5/9/13 in room watching television.</p> <p>Review of Resident #42's clinical record on 5/7/13 at 11:00 a.m. indicated a previous medical history including, but not limited to, high blood pressure, anxiety, and hard of hearing. The clinical record also indicated Resident #42 preferred individual activities and to have the newspaper daily.</p> <p>An interview with the AD on 5/9/13 at 3:00 p.m. indicated Resident #42 rarely leaves his room to participate in group activities. AD was not able to identify individualized activities for the resident.</p> <p>3.1-33(a)</p>				

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F000250 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 record review and interviews, the facility failed to ensure medically-related social services were provided to residents in preparation to transition back to home/another facility; and failed to follow-up on and obtain a resident's glasses after having payment approved. This deficient practice affected 5 of 6 residents reviewed for discharge planning. (Residents #A, B, D, F and G); and 1 of 1 resident reviewed for vision services. (Resident #H)</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #A on 5/7/13 at 2:35 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia with severe behavior disturbance, anxiety, psychosis, depression and schizo affective disorder - bipolar type.</p> <p>During an interview with the responsible party for Resident #A on 5/2/13 at 1:34 p.m., she indicated that the resident had been transferred to</p>	F000250	<p>Resident's #A, B, D, F, G and H were listed in the complaint sample therefore the facility was not given their names. A one time audit of the current resident population has been completed to ensure discharge planning is documented in the medical record and any outstanding ancillary services have been received as ordered. Resident's identified as short term will have current care plans and social service progress notes reviewed to ensure resident involvement and preparation in the discharge process is documented. The Social Services Director and Social Services Assistant will be re-educated on the Discharge Management and Vision Services Policy and Procedures. The Administrator/Designee will complete an audit of current residents scheduled to discharge in next 7 days in order to validate social services documentation of resident involvement in the discharge process. This audit will be completed weekly for 8 weeks, monthly for 6 months, and then quarterly for 1 quarter. The Social Service Director will complete a monthly summary of</p>	06/06/2013

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	<p>the hospital on 1/5/13 with the anticipation of them adjusting her medications for better behavior management and then she would return as she has done on several occasions in the past year.</p> <p>She indicated that on 1/25/13, she had received a call from Social Worker #1 telling her the DoN [Director of Nursing had made the decision for the resident to not be accepted back to the facility due to thoughts the facility could not manage her care as there was little change in her behaviors. The Social Worker then informed the responsible party that she had made a referral the day before to another facility she felt might be more appropriate for the resident and was just waiting on confirmation of acceptance.</p> <p>The responsible party indicated that she was unable to get much information from the Social Worker as to where the building was located exactly or actual name of the facility and that she had to contact the hospital where the resident currently was to get any information of where the resident was supposed to be transferred to. She indicated she had tried to stop the transfer until she could speak to the staff at the nursing</p>		<p>the # of residents seen for vision services that required new/replacement eye glasses and date glasses were received. Any identified concern will be immediately addressed, 1:1 re-education completed. Continued non-compliance will result in disciplinary action, up to and including termination, as per policy. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two quarters. Any further action will be as determined by the QPI committee. Date of compliance June 6, 2013.</p>	

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	<p>home, but indicated that by the time she could finally talk to someone, the resident was ready to be discharged to the new facility. She indicated that she had tried to call the Social Worker, the Administrator and the DoN but no one would take her calls. She also indicated that she also had been told by the nursing home that even as Power of Attorney, she could not stop the transfer from happening because all arrangements had been made, the resident's bed was no longer available and her belongings had been packed.</p> <p>During an interview with Social Worker #2 on 5/8/13 at 3:00 p.m., she indicated she was the one who also called the family and informed them the resident would not be accepted back to the facility. She indicated that although she had made the referral to another facility on 1/24/13, she had left several messages for the family also on that day. She indicated that because she had not heard back from the family, she went ahead and made the referral and then finally got in touch with them the next day.</p> <p>The Social Worker indicated that initially it was thought that the resident would come back and that the Administrator had signed a notice</p>				

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	<p>which stated the facility had intended to take the resident back when ready.</p> <p>During the interview, the Social Worker said the facility would have taken the resident back if they had to, but because she had found alternate placement, the plan to not take her back stood. She also indicated that because she had already found a facility that was going to take the resident, she did not give the family any choices as to what facility they might like to transfer the resident to, nor work with them on ways of being able to allow the resident to come back.</p> <p>2. Review of the clinical record for Resident #B on 5/7/13 at 12:21 p.m., indicated the resident was admitted to the facility on 1/19/13 for short term rehab and wound healing.</p> <p>The 1/21/13 Admission MDS [Minimum Data Set] Assessment indicated the discharge plan for the resident was to return to the community when able and that a referral for community services may be needed. The resident scored a 15/15 on BIMS [Brief Interview Mental Status] which indicated the resident was cognitively intact and able to make own decisions.</p>				

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	<p>On 1/31/13, a application was made by the resident for Medicaid Waiver services in the community. No further documentation regarding the waiver eligibility and future plans could be located.</p> <p>A 2/3/13 Social Service note indicated the resident was to go to a facility closer to family. Documentation was lacking of the resident being involved in the decision.</p> <p>A 2/8/13 Social Work note indicated that during a conversation with the local mental health office, the Social Worker was informed of the resident leaving this current facility when the resident's POA found placement closer to family. The Social Worker also indicated in the note that she had made a referral to another Assisted Living facility (name not identified in notes) but that they were full at this time. No further documentation regarding discharge planning or resident being included in the discussion could be located.</p> <p>A 2/8/13 IDT [Interdisciplinary Team] note indicated the family wanted the resident closer to home at this time.</p> <p>On 4/11/13, the physician gave an</p>						

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	<p>order for "May DC [discharge] to Assisted Living Community" and a "Notice of Transfer/Discharge" was completed and sent with resident.</p> <p>On 4/11/13, a Social Service Discharge Summary was completed at noon which indicated the resident was going to [name of facility] Assisted Living to be closer to family; that a family meeting was held on 4/4/13; and that no referrals were needed.</p> <p>Review of the Social Work notes for 4/4/13 failed to locate documentation of a family meeting regarding discharge as well as a lack of documentation of a discussion being held with the resident as to where she was to be discharged to, and how she felt about discharge in order to prepare her for discharge.</p> <p>During an interview with Social Worker #1 on 5/8/13 at 1:40 p.m., she indicated that at first the resident didn't want to go and that because the original facility she was to go to was full, no one was in a hurry to look for alternate placement. She also indicated the resident had experienced some family losses at the time which also contributed to her delay in being discharged.</p>			

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	<p>3. Review of the clinical record for Resident #D on 5/7/13 at 2:20 p.m., indicated the resident was admitted to the facility on 2/8/13 for short term rehab after a bout of pneumonia and was discharged to home on 3/7/13.</p> <p>The 2/11/13 Initial Social Work note indicated the resident's plans were to rehab to build strength and return home.</p> <p>A 2/11/13 "Discharge Plan: Plan of Care" : included interventions such as: "discuss discharge goals with resident's family; assess for need for DME [durable medical equipment] or home health services prior to d/c; Plan family meeting as needed; update resident/family/physician on discharge goals of progress."</p> <p>The 2/26/13 14 day Admission MDS Assessment indicated the resident scored a 12/15 on the BIMS test which indicated the resident needed an occasional reminder but was cognitively able to make own decisions. The assessment also indicated an active D/C [discharge] plan was in effect and that referrals may be needed.</p> <p>On 3/5/13, an MD [physician] order</p>			

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	<p>was received for "resident to d/c home 3/7/13 with VNA [Visiting Nurse Association] home health."</p> <p>A 3/6/13 Social Work note indicated the "resident will be leaving tomorrow on 3/7/13 to go to [name of private group home] Assisted Living. Will be followed by VNA also. Son to transport."</p> <p>The 3/7/13 Social Work note also indicated the same as on 3/6/13 about being discharged.</p> <p>A 3/7/13 Nursing note at 4:00 p.m. indicated "DC to [name of group home]..."</p> <p>On 3/7/13, a Social Service Discharge Summary completed by Social Work at 4:00 p.m., indicated the resident will go to assisted living with home health to follow; a referral to VNA was made and a family meeting was held on 3/2/13. Documentation was lacking of the discussion with the family and the resident regarding discharge planning, services needed and who would provide and adequate preparation with the resident for the move, including how the resident felt about discharge and where she was to go.</p>			

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	<p>During an interview with Social Worker #1 on 5/8/13 at 2:00 p.m., she indicated the resident's family member made the arrangements for the private group home since the resident returning to her home was not an option. The Social Worker also indicated she did not talk specifically to the resident about not going home nor about the private group home and guessed that the resident was okay with the arrangements made.</p> <p>4. Review of the clinical record for Resident #F on 5/6/13 at 10:25 a.m., indicated the resident was admitted to the facility on 1/3/13 and discharged to another facility on 2/25/13. Diagnoses included, but were not limited to: dysphagia; head/neck/throat cancer; and toxic metabolic encephalopathy.</p> <p>A 1/4/13 Care Plan was implemented "Problem: Potential for Complication r/t [related to] discharge planning - decreased health and ability to care for self". "Goal - Possible LTC [long term care]". "Approaches: Schedule the appointments as needed. Plan family meeting as needed".</p> <p>A 1/10/13 Social Service Progress Note indicated "Discharge Plan review - Possible LTC - unsure at this</p>						

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	<p>time."</p> <p>A 1/4/13 Social Service Assessment/Discharge Evaluation completed with the resident indicated he would like to return home if possible but was unsure at this time. The Discharge Plan section was also blank.</p> <p>A 2/22/13 Social Service note indicated "Received phone call from [name of facility] in [town name]. Family wants resident to move there. Have faxed paperwork. Resident to go there on Monday to live closer to family." Documentation was lacking by Social Services of having spoken to the resident to determine if this was the facility he wanted to go to and how he felt about moving.</p> <p>During an interview with Social Worker #1 on 5/8/13 at 1:10 p.m., she indicated she was aware of the family looking to transfer the resident to another facility as they wanted him closer to them. She indicated she did not include him in the planning process and was unsure if the family had spoken to him about moving as she did not.</p> <p>5. Review of the clinical record for Resident #G on 5/7/13 at 11:20 a.m.,</p>						

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	<p>indicated the resident was admitted to the facility on 12/11/12 for short term rehab after a bout of pneumonia and was discharged back to home with his mom as caregiver on 12/27/12.</p> <p>Diagnoses included, but were not limited to: status post motor vehicle accident, seizures, traumatic brain Injury, hypoxia, chronic pain syndrome, and insulin dependent diabetes mellitus.</p> <p>Review of the undated Social Service Assessment/Discharge Evaluation Short Stay indicated the resident's Discharge Goal was listed as "Unknown." This document was also incomplete for Prior Residence, Community Resources, and Discharge Obstacles.</p> <p>Care plans, dated 12/11/12, for "Short Stay" and "Discharge Planning" both indicated approaches of discussion of discharge status regularly with resident and family throughout stay on progress towards and plans for discharge; assist with need for health services prior to discharge; and plan family meeting as needed.</p> <p>The 12/16/12 and 12/20/12 Social Service Progress Notes indicated the resident's family called or visited almost daily and were very</p>			

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	<p>supportive. Both Discharge Plan Reviews indicated the plan was to return to community. The notes also indicated the resident was able to make needs known without difficulty.</p> <p>On 12/20/12, a Physician Order was received which indicated that the resident may discharge to home on 12/27/12.</p> <p>A 12/21/12 Social Service Progress note indicated "Resident mother and brother called today. Will do phone conference with them on Thurs [Thursday] afternoon. Resident will d/c to home on thurs or Friday." Documentation was lacking of any further communication with the family or with the resident to prepare him to go home.</p> <p>On 12/27/12 at 3:30 p.m. (at the time the resident was being prepared by nursing for discharge), the Social Worker completed a Social Service Discharge Summary in which she indicated she met with the family at this time. She indicated no referrals were needed, the resident and family were notified and that the resident would see his Primary MD in the morning.</p> <p>An Intake Referral Form was also</p>				

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	<p>completed on this date which detailed the reason why the resident was in the facility and to request services for nursing to help with meds, home care services and therapy if needed.</p> <p>During an interview with Social Worker #1 on 5/8/13 at 1:50 p.m., she indicated the resident talked everyday about going home but also indicated she did not talk with him about any arrangements and how he felt about going home. She also indicated that at one point, the resident's brother was looking into the resident going to an Assisted Living facility. Documentation was lacking of any follow-up with the family on the resident possibly going to Assisted Living.</p> <p>On 5/9/13 at 9:10 a.m., the Director of Nursing presented a copy of Social Worker #1's signed Job Description dated 5/18/11. Review of this Job Description at this time included, but was not limited to: "...11. Attends and participates in the Plan of Care meetings with emphasis on medically related social services including Discharge Planning...13. Refers residents/patients to appropriate agencies when discharge is anticipated...14. Services as primary resident/patient/family liaison</p>				

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	<p>regarding communication and development of interdisciplinary treatment and/or discharge plan..."</p> <p>The Director of Nursing also presented a copy of Social Worker #2's signed Job Description dated 4/8/08. Review of this Job Description at this time included, but was not limited to: "...6. Assists in conducting a pre-discharge evaluation. 7. Assists with discharge planning..."</p> <p>The Director of Nursing presented a copy of the facility's current policy titled "Discharge Management - Social Worker". Review of this policy at this time included, but was not limited to: "...1. Social Worker will:...f. counsels resident/caregiver about community reintegration services, center's, and support systems available in the community to meet physical, mental, and psychosocial needs of the resident/caregiver..."</p> <p>6. Resident #H was observed without glasses on 4/30/13, 5/1/13, 5/2/13, 5/6/13, 5/7/13, and 5/9/13. During an interview on 5/2/13 at 2:11 p.m. Resident #H indicated a pair of eye glasses was missing "around last October or November." The resident reported the facility scheduled an appointment with the optometrist a "few months ago" but the glasses had</p>			

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	<p>not been replaced as of the date of the interview.</p> <p>Review of the clinical record on 5/6/13 at 11:13 a.m. indicated the resident was seen by the facility optometrist on 2/13/13 and was prescribed glasses.</p> <p>The Social Services Director (SSD) indicated in an interview on 5/10/13 at 11:00 a.m. it was her responsibility to assist residents with concerns. Review of the concern log on 5/10/13 at 11:00 a.m. did not include the missing eye glasses.</p> <p>The SSD also indicated in an interview on 5/10/13 at 11:00a.m., it was her responsibility to make referrals including follow up for eye care. SSD was not aware Resident #H had not received her glasses. SSD indicated, "I don't know but it shouldn't take that long."</p> <p>This federal tag relates to complaint IN00123454.</p> <p>3.1-34(a)</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update the resident's care plan when placement changed from short term stay to long term care. This deficient practice affected 1 of 7 resident discharge care plans reviewed. (Resident #E)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #E on 5/9/13 at 2:48 p.m., indicated the resident had diagnoses which included, but were not limited to: hypertension, coronary artery disease, congestive heart failure,</p>	F000280	Resident E was listed in the complaint sample. The facility was not given Resident E's name. Current residents will be reviewed to ensure discharge care plans accurately reflect that resident's short or long term status. The Social Services Director and Assistant will be re-educated on the facilities discharge management policy and procedure. The Administrator/Designee will complete an audit of discharge care plans for 10% of current residents, weekly for 12 weeks, monthly for 6 months, and then quarterly for 1 quarter, to ensure short or long term status is identified and accurate per the	06/06/2013			

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	<p>diabetes mellitus type 1, generalized weakness, and chronic urinary tract infection.</p> <p>A 12/20/12 Social Work Admit note indicated it was unsure if the resident would remain long term care or not in the facility and that family was looking at alternate placement. No further documentation by Social Work regarding the resident's discharge plans or remaining long term care could be located.</p> <p>On 12/20/12, a "Social Services Short Stay Plan Of Care" was developed with review dates of 3/22/13 and 5/3/13. "Problem: resident is a short stay - maybe". "Goals: Be updated on status of discharge plan throughout length of stay. Be discharged to least restrictive and safest setting with min [minimum] assistance when appropriate. Be discharged to home when family is able to care for her." "Approaches: Discuss discharge status regularly with resident/family and update on progress. plan family meeting as needed. visit with resident to discuss problems, adjustment issues, concerns and discharge plans as needed."</p> <p>On 12/20/12, a "Discharge Plan: Plan</p>		<p>resident/responsible party. Any identified concern will be immediately addressed, 1:1 re-education completed. Continued non-compliance will result in disciplinary action, up to and including termination, as per policy. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two months. Any further action will be as determined by the QPI committee. Date of compliance June 6, 2013.</p>				

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	<p>of Care" was developed with a review date of 3/22/13. "Problem: Potential for complications r/t [related to] discharge planning - rehab, family unable to care for resident at this time." "Goal: will be discharged to least restrictive and safest setting with min [minimal] assistance when appropriate. Possible LTC [long term care]." "Approaches: Discuss discharge goals with resident/family. Plan family meeting as needed."</p> <p>A 3/13/13 IDT [Interdisciplinary team] note indicated the team met and reviewed the resident for a room change from one hall to another per family request and possibility of resident being LTC. The notes did not indicate if resident was to be LTC in the current facility or another facility.</p> <p>During an interview with Social Worker #1 and #2 on 5/9/13 at 4:45 p.m., they indicated "the resident was supposed to go to another facility near by but no bed was available and now son is planning on her to stay here all along. Granddaughter still hoping that if resident gets stronger, she might go home. Guess it's not documented. We've discussed it several times."</p> <p>On 5/9/13 at 9:10 a.m., the Director of</p>			

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	<p>Nursing presented a copy of the facility's current policy titled "Discharge Management Interdisciplinary Team". Review of this policy at this time included, but was not limited to: "...Procedure:...If the resident level of clinical care changes, the discharge plan and date will be re-evaluated...2....b. The Social Worker/Discharge Planner is responsible for facilitating the discharge process..."</p> <p>This Federal tag is related to Complaint IN00123454.</p> <p>3.1-35(2)(d)(B)</p>			

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F000309 SS=D	<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 interview and record review, the facility failed to provide a comprehensive assessment for 1 of 3 residents receiving dialysis services. (Resident #7).</p> <p>Findings include:</p> <p>Review of the clinical record on 5/7/13 at 2:45 p.m. indicated Resident #7 received outpatient dialysis services three times a week. Resident #7's medical history includes, but is not limited to, renal failure, hypertension, and head trauma.</p> <p>An interview with RN #1 on 5/7/13 at 11:22 a.m., indicated the facility nurse is responsible for pre and post dialysis assessment. RN #1 indicated the facility is responsible for sending a dialysis center communication form with the resident to dialysis and the forms are kept in the resident's medical record.</p>	F000309	Resident #7 is currently receiving comprehensive assessments per the facility's dialysis policy. Licensed Nurses will be re-educated on the Dialysis Management policy and procedure. The Unit Manager will complete an audit, weekly for 12 weeks, monthly for 6 months, and then quarterly for 1 quarter, to ensure the Dialysis Center Communication Records for residents receiving dialysis have completed pre and/or post dialysis assessments. Any identified concern will be immediately addressed, 1:1 re-education completed. Continued non-compliance will result in disciplinary action, up to and including termination, as per policy. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two months. Any further action will be as determined by the QPI committee. Date of compliance June 6, 2013.	06/06/2013	

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	<p>Review of the clinical record indicated documentation was lacking of the communication form to be used. In addition, documentation of complete pre and/or post dialysis assessment was lacking.</p> <p>An interview with the Director of Nursing on 5/7/13 at 3:25 p.m., indicated the facility nurse should complete the dialysis center communication record in its entirety before and after dialysis. The Assistant Director of Nursing reported on 5/7/13 at 3:30 p.m. the dialysis center sometimes does not send the form back with the resident.</p> <p>A copy of the policy and procedure of Dialysis Management, provided by the Director of Nursing on 5/8/13 at 9:05 a.m., indicated the Dialysis Center Communication Record is to be used for continuity of care between the facility and dialysis.</p> <p>3.1-37(a)</p>				

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F000312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review, the facility failed to provide necessary services to maintain grooming and personal hygiene. This deficient practice affected 4 of 7 sampled residents requiring assistance with personal hygiene (Resident #42, #88, #104, H).</p> <p>Findings include:</p> <p>1. Resident #42 was observed unshaven on 4/30/13 at 3:30 p.m. during an interview. Resident #42 indicated he preferred no facial hair. Review of the MDS assessment in the clinical record, on 5/1/13, indicated the resident required limited assistance with personal hygiene. The clinical record also lacked documentation to indicate Resident #42 refused grooming. An interview with CNA #3 on 5/10/13 at 4:30 p.m. indicated resident is able to shave independently with minimal assist.</p>	F000312	Resident #42 remains able to shave independently with minimal assistance; however, the care plan has been updated to reflect resident's right to refuse daily grooming. Resident #88 has had upper and lower dentures cleaned and is currently receiving daily oral care. Resident #104 is not identified on the Sample Resident List provided by the state surveyor upon exit. Resident #3 has had teeth brushed and is currently receiving daily oral care. Resident # H was listed in the complaint sample therefore the facility was not given their name for follow up. A one time review of current resident population has been completed to ensure shaving capabilities and preferences are noted on the resident care plan, as well as dental care assistance. The nursing staff will be re-educated on the importance of carrying out activities of daily living (ADL) for those residents that are unable to perform their own ADL care. Nurse Supervisors will complete shift rounds focusing on resident grooming, daily times 14 days, weekly for 6 weeks, monthly for 4 months, and then quarterly for 2	06/06/2013			

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	<p>2. On 4/30/13 at 3:06 p.m., Resident #88 was observed to have cream-colored particles at the base of the upper and lower dentures. Review of the MDS assessment in the clinical record, on 5/1/13, indicated Resident #88 required extensive assistance with personal hygiene.</p> <p>3. Resident #104 was observed unshaven on 5/7/13 at 10:41 a.m. Review of the MDS in the clinical record on 5/1/13 indicated the resident required limited assistance with personal hygiene.</p> <p>4. During an observation on 5/1/13 at 9:11 a.m., Resident #3 was found to have cream colored particles on most teeth. During an interview at this time, the resident indicated teeth are brushed monthly. Resident #3 has a medical history included but not limited to multiple sclerosis and required maximum assist.</p> <p>5. During an interview on 5/2/13 at 2:38 p.m., Resident H indicated "they just stopped letting us brush our teeth, and that's a big thing with me" and prefers to brush teeth daily. Review of the MDS assessment in the clinical record on 5/6/13 at 11:11 a.m.. indicated resident required</p>		<p>quarters. In addition, rounds will be completed by managers to ensure overall grooming is maintained weekly for 8 weeks, monthly for 4 months, and then quarterly for 2 quarters. Any identified concern will be immediately addressed, 1:1 re-education completed. Continued non-compliance will result in disciplinary action, up to and including termination, as per policy. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two months. Any further action will be as determined by the QPI committee. Date of compliance will be June 6, 2013.</p>				

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	<p>extensive assistance with personal hygiene.</p> <p>An interview with CNA # 2 on 5/7/13 at 10:30 a.m., indicated oral care is provided for residents every morning and night.</p> <p>An interview with CNA #3 on 5/10/13 at 4:30 p.m. indicated residents are shaved twice a week.</p> <p>On 5/9/13 at 5:51 pm LPN #1 indicated CNA's are responsible for personal hygiene and grooming of residents. LPN#1 reported all CNA's are educated from the Textbook for Nursing Assistants which is available on each unit for reference. Review of Cleanliness and Hygiene chapter indicated teeth should be brushed daily and most men shave their faces daily.</p> <p>3.1-38(a)(3)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167		
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F000507 SS=D	<p>483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS</p> <p>The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.</p> <p>Based on record review and interview, the facility failed to ensure residents' lab results were filed in the clinical records in a timely manner. This deficient practice affected 2 of 3 residents reviewed for lab results. (Residents #A and C)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the clinical record for Resident #A on 5/7/13 at 2:35 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia with severe behavior disturbance, anxiety, psychosis, depression and schizoaffective disorder - bipolar type. <p>On 1/3/13, a physician's order was received for "May obtain a UA [urinalysis] with C&S [culture and sensitivity] if needed" due to the resident experiencing increased behaviors.</p> <p>A 1/3/13 Nursing note indicated the results were negative and the physician had been notified.</p>	F000507	<p>Resident's #A and C were listed in the complaint sample. The facility was not given their names. A one time audit of lab results for the last 60 days has been completed to ensure lab results are located on the medical record. Licensed Nurses will be re-educated on ensuring lab results are filed timely in resident's medical chart. It is the responsibility of the Licensed Nurse to file the lab results on the medical record once they have been received. An audit will be completed by Medical Records to ensure lab results are available in the resident's medical record, weekly for 12 weeks, monthly for 2 months, and then quarterly for 2 quarters. Any identified concern will be immediately addressed, 1:1 re-education completed. Continued non-compliance will result in disciplinary action, up to and including termination, as per policy. The results of the audits will be submitted to Quality Performance Improvement Committee monthly for 6 months, and then quarterly for two months. Any further action will be as determined by the QPI committee. Date of compliance June 6, 2013</p>	06/06/2013	

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	<p>Documentation was lacking of the results having been filed in the resident's clinical record.</p> <p>2. Review of the clinical record for Resident #C on 5/9/13 at 2:25 p.m. indicated the resident had diagnoses which included, but were not limited to: history of UTIs [urinary tract infections].</p> <p>On 3/7/13 at 9:30 p.m., a physician's order was received to obtain a stool culture for C- Diff [Clostridium Difficile - an intestinal infection] due to foul smelling stool. Documentation was lacking of the results having been filed in the clinical record.</p> <p>During an interview with the Admissions Coordinator on 5/9/13 at 4:10 p.m., she indicated "both labs should have been in the clinical record already - not sure why they are not as it has been long enough. Will request new labs be faxed from the lab."</p> <p>During an interview with the DoN [Director of Nursing] on 5/9/13 at 5:00 p.m., she indicated that the process was that when the labs come back, they are called to the MD [physician] for any orders, filed in the MD's folder for review and signature and then as</p>			

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	<p>soon as the nurses can, they put them in the clinical record. She did indicate that both lab results should have already been in the clinical records by now.</p> <p>This Federal tag is related to Complaint IN00123454.</p> <p>3.1-49(f)(4)</p>			