STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR NORTH	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 25, 26, 29, 30, 31, and February 1, 2018 Facility number: 000067 Provider number: 155143 AIM number: 100267880 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 8 Medicaid: 38 Other: 21 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 8, 2018.	F 0000	Please consider this Plan of Correction as our allegation of compliance. Disclaimer: Meadows Manor North Retirement and Convalescent Center, Inc. (Meadows) does not believe and does not admit that any deficiencies existed before, during or after survey. Meadows reserve all rights to contest proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Meadows reserves all rights to raise all possible contentions and defenses is any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correcting should be considered as a waiver or any potential applicable peer review, quality assurance or self critical examination privileges which Meadows does not waive and reserve the right to assert in any administrative civil or criminal claim, action or proceeding. Meadows offer its response, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to its residents.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, record review, and interview, the facility failed to ensure a treatment and a care plan were in place for a resident with a contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of the joint) for 1 of 1 residents reviewed for contractures (Resident 19). Findings include: 1. During an observation, on 1/25/18 at 9:42 a.m., Resident 19 was lying in bed, no left hand splint was in place. During an observation, on 1/29/18 at 9:22 a.m., Resident 19 was lying in bed, no left hand splint was in place. During an observation, on 1/29/18 at 11:34 a.m., Resident 19 was lying in bed, no left hand splint was in place. During an observation, on 1/29/18 at 2:53 p.m,	F 0688	It is the policy of the facility to ensure that all residents who enter the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range is unavoidable. Resident #19 Electronic Medical record was updated on February 9, 2017 to include the application of the air splint to left hand. The medical record will note the days of her refusal to wear the splint. Her care plan was also updated to include the application of the splint as she tolerates. The Director of Nursing audited all the residents' records and therapy records to ensure all contracture splints have been added to the Electronic Health record. Additionally, the Director of Nursing audited the care plan to the	02/09/2018

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	Resident 19 was lying in bed, no left hand splint was in place. During an observation, on 1/30/18 at 10:05 a.m., Resident 19 was lying in bed, no left hand splint was in place. At the same time, Resident 19 indicated she was unable to open her left hand. Resident 19's record was reviewed on 1/29/18 at 9:27 a.m. An annual Minimum Data Set (MDS) assessment, dated 11/11/17, indicated Resident 19 had a severe cognitive impairment. Diagnoses in the diagnosis and allergy section of the chart included, but were not limited to, altered mental status unspecified and unspecified dementia with behavioral disturbance. A physician's order, dated 9/22/17, indicated occupational therapy (OT) was to evaluate and treat related to left hand contracture. A physician's progress note, dated 10/18/17, indicated Resident 19's left hand was contracted and appeared to be in pain with examination. OT was to evaluate and treat related to left hand contracture. A nurse's note, dated 10/25/17, indicated a new order was received for a left hand splint. A physician's order, dated 10/25/17, indicated Pucci air splint was to be applied to left hand daily for 8 hours as tolerated. Skin was to be checked before and after application and as needed. An OT therapist progress and discharge summary, signed 10/26/17, indicated staff education was completed regarding the implementation of a splint. Resident 19 was to wear the splint to the left hand for at least 8 hours daily.		identified residents to ensure all splints are properly care planned. All care plans are up to date. To ensure future compliance Therapy will give a copy of the splint recommendation to the charge nurse and the Unit Manager to input the order into the EHR. Therapy will also discuss splint recommendations during morning IDT meeting. During IDT the Care Plan coordinator will be notified of the order/recommendation for a contracture splint. The DON or Designee will ensure the EHR reflects the order. The DON or designee will review the care plan to ensure compliance. All care plans will be reviewed at least quarterly by the IDT team. The IDT team will report to the QAPI committee any further concerns. The QAPI committee will initiate a PIP if further concerns are identified.	

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A Treatment Administration Record (TAR), dated October 2017, indicated Resident 19's left hand splint was documented as in place 10/25/17 through 10/31/17.

A TAR for December 2017 and January 2018 were reviewed and there was no indication of Resident 19's left hand splint being applied or refused.

Current care plans were reviewed, and no care plan for the left hand contracture was observed.

During an interview on 1/30/18 at 10:08 a.m., the MDS coordinator indicated there was no restorative nursing program. Resident 19 received range of motion services from the floor staff, but there was no documentation.

During an interview on 1/30/18 at 10:10 a.m., Qualified Medication Aide (QMA) 10 indicated Resident 19 had a left hand splint, but she thought it had been discontinued.

During an interview on 1/30/18 at 10:28 a.m., the MDS coordinator indicated Resident 19 did still have an order for the left hand splint. It was on the Certified Nursing Assistant (CNA) assignment sheet. It probably should have been on the TAR for documentation. The left hand splint should have been care planned because there was a physician's order for the splint and occupational therapy had treated the resident.

During an interview on 1/30/18 at 11:24 a.m., CNA 11 indicated Resident 19's hand splint should have been applied during the day.

During an interview on 1/30/18 at 11:34 a.m., the Director of Nursing (DON) indicated splints should have been documented on the TAR. Resident 19's

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	splint and contracture should have been on the care plan. During an interview on 1/30/18 at 11:42 a.m., the MDS coordinator indicated if therapy provided instructions after a resident was discharged from therapy then the resident's care plan should have been updated with that information. On 1/30/18 at 1:25 p.m., the Administrator provided a document titled, "Physician Services Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "...Physician supervision of care also includes writing orders for all necessary care and treatment...." On 1/30/18 at 1:25 p.m., the Administrator provided a document titled, "Policy and Procedure Care Planning," and indicated it was the policy currently being used by the facility. The policy indicated, "Care plans are developed for each resident to assist in providing the appropriate care and services needed by the individual. Care plans and care/services are to be modified based on the resident's needs...The care plan must describe the following. (i) The services that are to be furnished to attain or maintain the resident's highest practical level physical, mental, and psychosocial well-being. (ii) Any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment...." 3.1-42(a)(2)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure hot water temperatures were maintained within safe range for 10 of 24 residents reviewed for accidents (Residents' 1, 9, 18, 28, 29, 38, 48, 52, 57, and 65). Findings include: 1. During an observation, the Maintenance Director checked the water temperature on 1/15/18 at 10:19 a.m. Residents' 29, and 52 shared bathroom had a hot water temperature of 122 degrees Fahrenheit (F) per the facility's thermometer. a. Resident 29's record was reviewed on 1/29/18 at 2:02 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/15/17, indicated Resident 29 had a severe cognitive impairment. Diagnoses listed in the diagnosis section of the chart included, but were not limited to, unspecified dementia (a disorder of the mental processes caused by brain disease or injury) without behavioral disturbance. b. Resident 52's record was reviewed on 1/29/18 at 1:18 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 12/13/17, indicated Resident 52 was cognitively intact . Diagnoses listed in the diagnosis section of the chart included, but were not limited to, blindness (vision loss) both eyes, and cerebral palsy (neurological disorder). 2. During an observation, the Maintenance Director	F 0689	It is the policy of the facility that all residents remain free from Hazards. All staff and Residents were notified immediately of the hot water temperature. The maintenance director adjusted temperatures immediately. The facility performed hourly water temperature checks until the water temperature stabilized at 116 degrees. No residents were harmed due to the alleged incident. The facility performed daily temperature check for the next 30 days. Maintenance reported the temperature to the Administrator daily. The facility had 2 thermometers in the maintenance shop the director inadvertently grabbed the thermometer that was out of calibration which indicated the temperature was above 120 degrees. The thermometer has hence been disposed of. Maintenance will now calibrate the thermometer prior to checking the weekly temperature. The Maintenance Director will accompany the maintenance personnel at least 1 time per month for the next 3 months to ensure the proper temperatures and procedures are being followed. The Director will randomly accompany the maintenance personnel to ensure compliance for	02/05/2018

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	checked the water temperature on 1/15/18 at 10:21 a.m. Residents' 9, and 57 shared bathroom had a hot water temperature of 123 degrees Fahrenheit (F) per the facility's thermometer. a. Resident 9's record was reviewed on 1/29/18 at 2:21 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 10/26/17, indicated Resident 9 had a severe cognitive impairment. Diagnoses listed in the diagnosis section of the chart included, but were not limited to, peripheral vascular disease (a circulatory condition, narrowed blood vessels that reduce blood flow to the body's limbs) unspecified. During an interview on 1/29/18 at 2:51 p.m., Certified Nursing Assistant (CNA) 5 indicated Resident 9 was able to take himself to the bathroom. b. Resident 57's record was reviewed on 1/29/18 at 11:55 a.m. A 5 day Minimum Data Set (MDS) assessment, dated 12/22/17, indicated Resident 57 had a moderate cognitive impairment. Diagnoses listed in diagnosis section of the chart included, but were not limited to, dementia (a disorder of the mental processes caused by brain disease or injury), Parkinson's disease (disorder of the central nervous system that affects movement), and altered mental status. 3. During an observation, the Maintenance Director checked the water temperature on 1/15/18 at 10:23 a.m. Residents' 18, and 65 shared bathroom had a hot water temperature of 122 degrees Fahrenheit (F) per the facility's thermometer. a. Resident 18's record was reviewed on 1/22/18 at 1:41 p.m. A quarterly Minimum Data Set (MDS)		the next 12 months. The Maintenance Director will inform the Administrator of any concerns identified.	

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assessment, dated 11/10/17, indicated Resident 18 had a severe cognitive impairment.

Diagnoses listed in the diagnosis section of the chart included, but were not limited to, unspecified dementia (a disorder of the mental processes caused by brain disease or injury) without behavioral disturbance.

b. Resident 65's record was reviewed on 1/29/18 at 1:52 p.m. A quarterly MDS assessment, dated 10/24/17, indicated Resident 65 had a severe cognitive impairment.

Diagnoses listed in the diagnosis section of the chart included, but were not limited to, unspecified dementia without behavioral disturbance.

4. During an observation, the Maintenance Director checked the water temperature on 1/15/18 at 10:25 a.m. Residents' 28, and 48 shared bathroom had a hot water temperature of 123 degrees Fahrenheit (F) per the facility's thermometer.

a. Resident 28's record was reviewed on 1/29/18 at 1:58 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/14/17, indicated Resident 28 had a severe cognitive impairment.

Diagnoses listed in the diagnosis section of the chart included, but were not limited to, unspecified dementia (a disorder of the mental processes caused by brain disease or injury) without behavioral disturbance, and Parkinson's disease (disorder of the central nervous system that affects movement).

During an interview on 1/29/18 at 10:16 a.m., Certified Nursing Assistant (CNA) 6 indicated Resident 28 was able to take herself to the bathroom.

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	b. Resident 48's record was reviewed on 1/29/18 at 9:31 a.m. A annual Minimum Data Set (MDS) assessment, dated 12/10/17, indicated Resident 48 had a severe cognitive impairment. Diagnoses listed in the diagnosis section of the chart included, but were not limited to, type II diabetes mellitus (a condition that affects the way the body processes glucose). During an interview, on 1/25/18 at 10:19 a.m., the Maintenance Director indicated water temperatures were checked weekly in 4 different locations and that a temperature above 120 was too hot and would have to be adjusted to reach a temperature of 120 or below.5. During an observation, the Maintenance Director checked the water temperature on 1/25/18 at 10:22 a.m. Residents' 38 and 1 shared bathroom had a hot water temperature of 123 degrees Fahrenheit (F) per the facility's thermometer. a. Resident 38's record was reviewed on 2/1/18 at 10:26 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/21/17 indicated Resident 38 had a moderate cognitive impairment. Diagnoses in the diagnosis and allergy section of the chart included, but were not limited to, unspecified dementia without behavioral disturbance. A care plan, last reviewed 11/21/17, indicated Resident 38 had a cognitive deficit related to occasional confusion and forgetfulness. During an interview on 1/25/18 at 10:32 a.m., Certified Nursing Assistant (CNA) 9 indicated Resident 38 required assistance of 1 staff to get into the bathroom. Once he was in the bathroom he was able to wash his hands and face himself.			

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	b. Resident 1's record was reviewed on 2/1/18 at 10:30 a.m. An annual MDS assessment, dated 12/28/17, indicated Resident 1 had a severe cognitive impairment. Diagnoses in the diagnosis and allergy section of the chart included, but were not limited to, unspecified dementia without behavioral disturbance. A care plan, last reviewed on 12/28/17, indicated Resident 1 had a cognitive deficit related to the diagnosis of dementia. During an interview on 1/25/18 at 10:22 a.m., the Maintenance Director indicated the water temperatures were checked weekly in varied rooms. The water temperatures were usually around 119 degrees F and should not have been above 120 degrees F. During an interview on 1/25/18 at 10:27 a.m., the Maintenance Director indicated the water was too hot and the tempering valve needed adjusted. During an interview on 1/25/18 at 2:40 p.m., the Administrator indicated the water temperatures were still about 123 degrees F and had not stabilized. It was still being worked on. During an interview on 1/25/18 at 2:48 p.m., the Administrator indicated the water temperatures were at 110 degrees F. On 1/29/18 at 3:07 p.m., the Administrator provided an untitled document and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of the facility to maintain proper water temperatures. The Hot water will range from 100 degrees and less than 120 degrees...."			

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	3.1-19(r)(1) 3.1-19(r)(2)			
F 0711 SS=D Bldg. 00	483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.			
	Based on record review and interview, the facility failed to ensure the physician signed and dated orders for medication to be administered, for 1 of 17 resident medication administration records reviewed (Resident 27). Findings include: Resident 27's record was reviewed on 1/30/18 at 10:28 a.m. The record's diagnosis page indicated the resident's current diagnoses included, but were not limited to, adult failure to thrive, psychotic disorder, depression, and aphasia (the inability or refusal to swallow). A document titled, "Physician's Order Sheet and Progress Note," indicated the physician's last documented progress note was dated 10/1/17. Review of the resident's Medication Administration Records (MARs) indicated the Physician's Orders,	F 0711	It is the policy of the facility that the physician writes, sign and date progress notes. Resident #27 was seen by his Primary Care Physician on February 13, 2018. The physician signed and dated his progress notes. The Administrator performed an audit an all residents progress notes are signed and dated per policy. The Medical Record Designee will review all medical charts and record on physician visit log the date of the last visit and when the next visit is due. The Designee will contact the physician 5 days prior to their required visit: will monitor daily for compliance. If the Physician has not seen the	02/14/2018

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	dated November 2017, December 2017, and January 2018, had not been signed and dated by the physician. During an interview, on 1/30/18 at 11:14 a.m., the DON (Director of Nursing) indicated the physician had not been in the facility to sign the Physician's Orders since October 2017. The facility had a difficult time getting the physician to come to the facility. The physician requested to continue to serve as Resident 27's primary care provider, even through he had stopped seeing all of his other facility resident's some time ago, because he felt his schedule did not allow time to come into the facility in a timely manner. During an interview, on 1/30/18 at 11:34 a.m., the MDS (Minimum Data Set) Coordinator indicated the physician was responsible to visit the facility every 60 days, to assess the resident, review all medications and treatments, and sign orders. The last documented note from the resident's physician was on his visit on 10/1/17. During an interview, on 1/30/18 at 11:38 a.m., the Administrator indicated Resident 27 was the only resident the physician had at the facility. She has had a difficult time getting the physician into the facility in a timely manner. On 1/30/18 at 1:25 p.m., the Administrator provided an undated policy titled, "Physician Services Policy," and indicated it was the policy currently being used by the facility. The policy indicated, ..."Physician visits. The physician shall review each resident's total program of care, including medications and treatments at each visit. The physician shall also sign and date all orders...." 3.1-22 (c)(1)		resident by the required deadline the resident and/or representative will be given a choice to be seen by the medical director or be sent to the physician's office. The Medical Records Designee will inform the Administrator of any resident that has not been seen within the required timeframe. The Administrator will inform the Medical Director during quarterly QA meeting of any physician routinely not being compliant. The Medical Director will follow up with the residents primary care physician regarding timeliness of the visits.	