STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155253	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOWOOD HEALTH PAVILION	**2455 TAMARACK TRAIL BLOOMINGTON, IN 47408**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a dressing change, was implemented as ordered by the physician, for a surgical wound for 1 of 3 residents reviewed for wound care. (Resident B). Findings Include: On [DATE]20 at 11:20 a.m., Resident B's clinical record was reviewed. [DIAGNOSES REDACTED]. Resident B's Minimum Data Set (MDS) admission assessment, dated 1/6/2020, indicated Resident B was cognitively intact. Review of Resident B's Treatment Assessment Record (TAR) dated 1/1/2020 - 1/31/2020, indicated physician order [REDACTED]. The order indicated to cleanse with normal saline, pat dry, soak 4x4 gauze with normal saline, wring out, apply to wound and cover with ABD pad and wrap with [MED]. Change every day. Review of the TAR indicated each day 1/18/2020 through 1/31/2020 was signed off by nursing. On [DATE] the DON was informed by an RN on Resident B's hall, Resident B's dressing was dated 1/25/2020, however [DATE] was signed off by LPN 1. Interview with the DON, on 3/11/2020 at 11:15 p.m., indicated she spoke with LPN 1 regarding the signing of the TAR and the dressing showing the previous day ([DATE]20), and LPN 1 indicated she did not know how to do a wet to dry dressing and she had signed it off with the intention of asking another nurse to help her, but that she had forgot to do so. Review of LPN 1's health and wellness department orientation checklist for a Licensed Practical/Vocational Nurse indicated, on 12/14/2019. LPN 1 was checked-off for wound dressing changes protocol and competencies. This Federal tag relates to Complaint IN 596. 3.1-37(a)
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure an irrigation solution was administered to a Foley (urinary) catheter as ordered by the physician for 1 of 3 residents reviewed for catheter care (Resident C) and the facility failed to ensure the staff followed a physician's orders [REDACTED]. Findings include: 1. The clinical record of Resident C was reviewed on 3/11/2020 at 10:30 a.m. [DIAGNOSES REDACTED]. Resident C's Minimum Data Set (MD'S) quarterly assessment, dated [DATE], indicated Resident C had an indwelling catheter and was cognitively intact. Physician order, dated 12/03/2019 (start date), indicated insert [MEDICATION NAME] Solution. Two vials per irrigation every night shift on every Monday,Wednesday, and Friday for catheter care and perform on days catheter is changed, IRRIGATION AND CLAMP CATHETER X 30 MINUTES-USE TWO VIALS! Accessdata.fda.com indicated, [MEDICATION NAME] Solution, irrigation was a sterile, non-pyrogenic irrigation solution for use within the lower urinary tract in the dissolution of bladder [MEDICATION NAME] (stone) of the struvite or apatite variety, and prevention of encrustation's of urethral catheters. Resident C's MAR (Medication Administration Record) dated 1/2/2020 - 1/31/2020, indicated LPN 1 (Licensed Practical Nurse) signed the MAR indicated [REDACTED]. Upon review, at that time, the DON (Director of Nursing) indicated she was informed by RN 1, checking the medication cart, that 2 vials of Encoding Solution were still in the medication drawer with the date of 1/22/2020, indicating LPN 1 signed the MAR, but did not administer the medication as indicated by the physician's orders [REDACTED]. On [DATE]20 at 2:47 p.m., the ADON (Assistant Director of Nursing) provided General Dose Preparation and Medication Administration, revised 01/01/13, and indicated the policy was the one currently being used by the facility. A review of the policy indicated, .Document necessary medication administration/treatment information (e.g. when medications are open, when medications are given,.application sight) on appropriate forms. 2. The clinical record of Resident D was reviewed on 3/11/2020 at 11:00 a.m. [DIAGNOSES REDACTED]. Resident D's Minimum Data Set (MDS), admission assessment dated [DATE], indicated Resident D was severely cognitively impaired. Resident D's order summary report, dated 1/28/2020 (no time noted) indicated for facility to obtain a U/A (urinalysis), C&S (culture and sensitivity) one time only for behaviors for 1 day. Interview with the DON, on [DATE] at 11:00 a.m., indicated during a care conference with Resident D's spouse, administrator and MDS coordinator, Resident D's spouse asked why Resident had to have the urine specimen by catheter. MDS checked Resident D's physician orders, and it was found there was no order for the urine specimen to be obtained by a catheter. The DON was not present, but was notified and an a investigation was initiated. The DON indicated during interview with LPN 1, she indicated she had obtained the urine specimen by a catheter, because the order read to obtain a clean catch sample. When the DON educated LPN 1 the difference between a catheter specimen and a clean catch specimen (no catheter) LPN 1 indicated she was not aware there was a difference. On [DATE]20 at 2:47 p.m., the ADON provided the Urine Specimen policy, effective date of 9/1/19, and indicated the policy was the one being currently used by the facility. A review of the policy indicated, This document sets forth the procedures to be followed for collecting a urine specimen for laboratory screening for urinary systemic disorders. Urinal: if the resident is a male and dependent, lift penis and retract foreskin. Wash with soap and water and dry thoroughly. This Federal tag relates to Complaint IN 596. 3.1-41(a)(1) 3.1-41(a)(2)

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.