STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(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
F000000	This visit was for the Investigation of Complaint IN00126860. Complaint IN00126860 - Substantiated. Federal/State deficiencies related to the allegations are cited at F204, F250, F406 and F425. Survey dates: May 16 & 17, 2013 Facility number: 001149 Provider number: 155618 AIM number: 200145500 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 51 SNF/NF: 31 Residential: 64 Total: 146 Census Payor Type: Medicare: 23 Medicaid: 31 Other: 92 Total: 146 Sample: 5	F000000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Qualtiy Review was completed by Tammy Alley RN on May 23, 2013.			

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F000204 SS=G	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Based on record review and interview the facility failed to ensure sufficient preparation and the safe discharge of a resident, in that when a resident who was unable to ambulate and required ancillary services to include durable medical equipment and coordination of services with other agencies, the facility failed to take appropriate steps to ensure the safe discharge on two separate occasions for 1 of 1 resident reviewed for discharge from the facility , and who required special needs in a sample of 5. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 05-16-13 at 9:41 a.m. Diagnoses included but were not limited to morbid obesity, deep vein thrombosis, diabetes mellitus, atrial fibrillation and a recent below the knee amputation. The resident weighed 524 lbs. at the time of discharge These diagnoses remained current at the time of the record review.	F000204	**F 204 SS=G Preparation for Safe/Orderly Transfer/Discharge** It is the practice of this center to comply with F 204 Preparation for Safe/Orderly Transfer/Discharge **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # A No longer resides at the Facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Residents that have diagnosis that require special needs and coordination of services with other agencies as part of their discharge plans have the potential to be affected and have been reviewed for appropriate discharge planning related to assistive devices, equipment needs, and documentation that services are coordinated to ensure a safe discharge. Observations will be recorded on the QAA monitoring tool and corrections will be completed by Administrative Director of Nursing Services/Designee and Director	06/14/2013

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	The resident was admitted to the facility on 12-19-12 after surgery which included a left below the knee amputation. A review of the resident's plan of care, originally dated 12-24-12 indicated the "patient shows potential for discharge and patient expresses wish for discharge." The "goal" for this focus indicated, "Will be discharged to home when clinical and rehabilitation goals are met." "Interventions" included "Assess future placement setting to determine if resident's needs can be met, discuss with patient, family, and/or representative the discharge planning process, investigate need for special equipment, home health physician follow up, and make referrals as needed." A review of the "Local Mental and Behavioral Health Visit Note," dated 02-15-13 indicated the resident "is concerned that rehab. [rehabilitation] has ended sooner than he expected and he will be discharged when he does not feel prepared. He stated the accommodation to his home are not complete, as well as having worries about his continued healing process. Pt. [patient] has experienced a		of Rehabilitation/ Designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The IDT (Inter disciplinary Team) has been in-serviced by the Administrator on the facility guideline for Discharge to Home or Non-institutional setting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** Monitoring of residents with discharge orders will be conducted 5 times weekly x 12 weeks, then monthly x 3 months by the Administrative Director of Nursing Services/Designee and Director of Rehabilitation/Designee to ensure that discharge plans address residents needs for assistive devices, equipment, as well as documentation that services are coordinated to ensure a safe discharge. Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance. **By what date the systemic changes will be completed?** June 14 th , 2013	

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	significant physical impairment that he was not prepared for. He has adjusted well, but he is now faced with the reality that he will be discharged back to his home. Recommendations for staff - Keep pt. informed of tx. [treatment] and d/c [discharge] planning to reduce worry." Review of the physician "Progress Note," dated 03-19-13 indicated "Pt. [patient] apparently discharging today to hotel [home]." A review of the State Form "Notice of Transfer or Discharge," dated 03-19-13 indicated the resident was "being transferred to a private residence." Interview on 05-16-13 at 11:00 a.m., the Social Service Director indicated in regard to the resident's discharge, "The freight elevator [at the apartment complex] was going to be out of service for 30 days and when therapy ended the apartment complex said they would put him up at a hotel until the freight elevator was repaired. He couldn't fit through the door [at the hotel] because it wasn't handicapped accessible. We depended on the apartment complex since he couldn't go back home. When the situation at the hotel wasn't working out, the			

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	ambulance took him to [name of hospital] but they couldn't keep him so they brought him back here. He came back to us and actually went back into the same room. He had a bariatric bed in his apartment and I thought all his needs were set up. I don't know about a bed side commode or a sliding board. I don't know how his bathroom was set up, but the amputation was new for him. As far as I know we didn't send orders to the Home Health Agency and they didn't ask for one." Interview on 05-16-13 at 1:15 p.m., the Therapy Director indicated, "We discharged him from therapies the middle of February [02-13-13]. He met his goals with us, but still had a skilled need with his amputation." When interviewed if anyone in therapy does a home evaluation prior to the discharge of a resident, the Therapy Director indicated, "We generally work off the 'floor plan.' We'll go if there seems to be a problem, but if we do, we assess the resident's ability to get around the apartment/home, not the apartment/home itself. I would say that, if for example we discharged twenty residents a month we might go to the home for one resident. At the time [name of resident] was			

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	discharged from therapy we didn't know where he was going. It wasn't until afterwards that we found out he was going to a hotel because of the broken freight elevator." Review of the "Occupational Therapy Summary," dated 02-13-13 indicated "Patient reached maximum functional potential at this time. He can now transfer with SBA [stand by assistance] of 1 and a sliding board and to a bedside commode with SBA...and should have a power chair, home O.T. [occupational therapy] home evaluation for home environment. D/C [discharge] recommendations wheelchair BSC [bedside commode] sliding board, hospital bed." A record review on 05-16-13 at 10:00 a.m., titled "Interdisciplinary Team Discharge Summary, dated 03-19-13, indicated "none" for the area specific to "special treatments or procedures planned for discharge." On 05-16-13 at 12:37 p.m., the Director of Nurses for the Home Health Agency was interviewed and indicated the following: "The whole thing was a mess. He originally lived on the fourth floor of			

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	the apartment complex. He needed to use the freight elevator to get from the ground floor to his apartment. When the freight elevator had not been repaired, they [employees at the apartment complex] decided to put him at [name of local area motel]. When he was released all they [the facility] did was tell them [apartment] he was going to be discharged and the lady at the [name of motel] was told he needed a handicapped accessible room. Supposedly he was only to be there over a weekend. He needed a bariatric bed, a trapeze, siderails and other things a new amputee needs. When I called the motel they told me they couldn't get him or the wheelchair through the front door or any other door at the motel. He [in regard to the resident] called to tell me what was going on and my understanding is that the ambulance crew took him to [name of local area hospital]. The hospital couldn't keep him so they took him back to Manor Care in Carmel. When I talked to them [at the facility] I told them the next time you guys release him make sure that when he comes home he can function and maneuver around the apartment, he is not mobile and if there had been a fire he would be history. The next time he was discharged, the ambulance crew			

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	got him up to his apartment and they had to put him in his recliner because his wheelchair was too wide to get through the bedroom or bathroom doorway. You don't just throw someone in an apartment. He had a urinal next to the recliner, but if he had a bowel movement, he couldn't get out of the recliner to take care of himself. When they discharged him they never even sent us orders. The nursing home just didn't do their part." During interview on 05-17-13 at 12:00 p.m., the Director of Nurses indicated that at the time of the resident "first" discharge, the resident was "picked up from the facility at 1:30 p.m., left the [name of the motel] at 4:22 p.m., left [name of the local area hospital] at 6:30 p.m., and returned to ManorCare at 8:35 p.m." A review of the "Home Health Nursing Visit Record," dated 03-22-13 after the resident was discharged a second time from the facility, indicated the following "skilled intervention" nurses note: "Had left BKA [below the knee amputation] at Indy VA, then spent time at ECF [extended care facility] for Rehab. [rehabilitation]. Able to use urinals next recliner in living room. Confined to living room due to wheelchair is 40 inches wide and			

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	doorways only 36 inches. Currently wearing adult brief in case bowels have to move. Has no prosthetic for left leg and is unable to use walker. Comfortable in recliner and has items he may need within reach. Phone and emergency button within reach. Has friend upstairs if he needs something minor. Glad to be home but unhappy he's unable to go thru doorways and is confined to living room at this time." A subsequent notation, dated 03-24-13 indicated the resident was unable to do "board transfers and stays in his chair." Review of a packet of information on 05-17-13 at 11:30 a.m., provided by the facility Social Worker, in regard to the facility "team approach to discharge planning," indicated the following: "The way a patient moves from a facility to the post discharge environment leaves a lasting impression." "A well planned discharge boosts patient and family confidence, increases patient safety, and gives the staff a sense of accomplishment. Focusing on patients being completely prepared to manage their care following discharge defines a			

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	successful discharge strategy." "Social services has the responsibility to act as a patient advocate. This involves: understanding the patient's expectations about returning to the post discharge environment, talking with the patient about the discharge date, focusing the patient on the overall goal of being completely prepared to manage care following discharge, communicating on the patient's behalf with the team and community resources to keep the patient's options flexible, evaluating the patient's post discharge care and service needs, setting up needed community resources to the patient has support in the post discharge environment." "Think strategically about anticipated discharges and bring structure to the way they are planned. This helps minimize last minute notifications and the patient benefits from the smooth transition." Review of facility policy on 05-17-13 at 12:00 p.m. at the Exit Conference, titled "Discharge Home or Non-Institutional Settings," dated 12-2009 indicated the following: "PURPOSE [bold type and			

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	underscored]: To provide safe departure from center to home or non-institutional setting." "PROCEDURE [bold type and underscored] - PRIOR TO DAY OF DISCHARGE - 1. Assess patient's health needs for discharge including nursing history, care plan and on-going assessments. 2. Ask patient/family for suggestions on ways to prepare for discharge, 3. Assess patient/family acceptance of health problems and related restrictions, 4. Assess patient/family needs for health teaching related to therapies to be continued at home, restrictions with self care activities, 5. Consult with other members of interdisciplinary team - registered dietitian, social worker, therapy, etc. regarding patient's needs on discharge, 6. Collaborate with physician and social worker in assessing need for referral to home health or other supportive agencies, 7. Offer patient/family information about community health care resources, 8. Complete referral forms indicating health care needs as well as existing functional abilities, 9. Suggest methods for altering physical arrangement of home environment to meet patient's needs." This Federal tag relates to Complaint			

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	IN00126860. 3.1-12(a)(21)			

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F000250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview the facility failed to ensure appropriate and safe discharge of a resident, in that when a resident who was unable to ambulate and required ancillary services to include durable medical equipment and coordination of services with other agencies, the social service director failed to take appropriate steps to ensure the safe and orderly discharged on two separate discharge dates for the resident. This inappropriate discharge process resulted in the resident being returned to the facility due to inappropriate accommodations and at the time of the second discharge the resident was confined to one area of the apartment, unable to access the bedroom or bathroom, and resulted in the resident sleeping in a recliner and defecating on self for elimination needs. This deficient practice affected 1 of 1 resident resident with diagnoses that required special needs at the time of	F000250	**F 250 SS=G Provision of Medically Related Social Services** It is the practice of this center to comply with F 250 Provision of Medically Related Social Services **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # A No longer resides at the Facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Residents that have diagnosis that require special needs and coordination of services with other agencies as part of their discharge plans have the potential to be affected and have been reviewed for appropriate discharge planning related to assistive devices, equipment needs, and documentation that services are coordinated to ensure a safe discharge. Observations will be recorded on the QAA monitoring tool and corrections will be completed by Administrative Director of Nursing Services/Designee and Director of Rehabilitation/Designee. **What**	06/14/2013

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	discharge, in a sample of 5. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 05-16-13 at 9:41 a.m. Diagnoses included but were not limited to obesity, deep vein thrombosis, diabetes mellitus, atrial fibrillation and a recent below the knee amputation. The resident weighed 524 lbs. at the time of discharge. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 12-19-12 after surgery which included a left below the knee amputation. Review of the resident's Minimum Data Set Assessment, dated 02-14-13 indicated the resident was not able to move "on/off the toilet" or "surface to surface transfer" without the assistance of another person. The assessment also indicated the resident was "frequently incontinent of bowel and bladder, and required extensive assistance with transfer and bed mobility." A review of the "Local Mental and		**measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Social worker has been in-serviced by the Social work Consultant on the Discharge Planning Checklist, Discharge Plan Update Process, and Documentation guidelines related to discharge planning. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** Monitoring of residents with discharge orders will be conducted 5 times weekly x 12 weeks, then monthly x 3 months by the Social Service Director/Designee and validated by the Administrator/designee to ensure appropriate steps has been taken for a safe and orderly discharge including addressing the residents needs for assistive devices, equipment, as well as documentation that services are coordinated. Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance **By what date the systemic changes will be completed?** June 14 th , 2013	

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	Behavioral Health Visit Note," dated 02-15-13 indicated the resident "is concerned that rehab. [rehabilitation] has ended sooner than he expected and he will be discharged when he does not feel prepared. He stated the accommodation to his home are not complete, as well as having worries about his continued healing process. Pt. [patient] has experienced a significant physical impairment that he was not prepared for. He has adjusted well, but he is now faced with the reality that he will be discharged back to him home. Recommendations for staff - Keep pt. informed of tx. [treatment] and d/c [discharge] planning to reduce worry." The resident was originally discharged from the facility on 03-19-13 after the completion of therapy services and wound care, and subsequently returned to the facility the same date due to inadequate discharge planning. During interview on 05-17-13 at 12:00 p.m., the Director of Nurses indicated that at the time of the resident "first" discharge, the resident was "picked up from the facility at 1:30 p.m., left the [name of the motel] at 4:22 p.m., left [name of the local area hospital] at 6:30 p.m., and returned to			

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	ManorCare at 8:35 p.m." Review of the physician "Progress Note," dated -3-19-13 indicated "Pt. (patient) apparently discharging today to hotel [home]." A review of the State Form "Notice of Transfer or Discharge," dated 03-19-13 indicated the resident was "being transferred to a private residence." Interview on 05-16-13 at 11:00 a.m., the Social Service Director indicated in regard to the resident transfer "The freight elevator [at the apartment complex] was going to be out of service for 30 days and when therapy ended the apartment complex said they would put him up at a hotel until the freight elevator was repaired. He couldn't fit through the door [at the hotel] because it wasn't handicapped accessible. The apartment complex employee said they checked it out and the hotel was handicapped accessible. We depended on the apartment complex since he couldn't go back home and they were paying for it. When the situation at the hotel wasn't working out, the ambulance took him to [name of hospital] but they couldn't keep him so they brought him back			

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	here. He came back to us and actually went back into the same room. His therapy had ended because he met his goals and therefore he didn't have a skilled need to be in a Medicare bed when he returned. We didn't have a Medicaid bed available and the Administrator got involved and the apartment complex agreed to pay the 'private rate' in the Medicare bed until the freight elevator was fixed. Shortly after he returned to us we received a call the the freight elevator was fixed and he could return home to his apartment. When the ambulance service came here to pick him up they actually called the apartment complex to make sure they didn't run in to the same problem as before. The Home Health agency didn't come out and evaluate him because they are in a different county. With a Home Health agency what we like them to do is to come out for the assessment because they need the orders anyway. They already knew him and were just going to re-open his case. He had a bariatric bed in his apartment and I thought all his needs were set up. I don't know about a bed side commode or a sliding board. I don't know how his bathroom was set up, but the amputation was new for him.			

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	As far as I know we didn't send orders to the Home Health Agency and they didn't ask for one." Interview on 05-16-13 at 1:15 p.m., the Therapy Director indicated, "We discharged him from therapies the middle of February [02-13-13]. He met his goals with us, but still had a skilled need with his amputation." When interviewed if anyone in therapy does a home evaluation prior to the discharge of a resident, the Therapy Director indicated, "We generally work off the 'floor plan.' We'll go if there seems to be a problem, but if we do we assess the resident's ability to get around the apartment/home, not the apartment/home itself. I would say that, if for example we discharged twenty residents a month we might go to the home for one resident. At the time [name of resident] was discharged from therapy we didn't know where he was going. It wasn't until afterwards that we found out he was going to a hotel because of the broken freight elevator." Review of the "Occupational Therapy Summary," dated 02-13-13 indicated "Patient reached maximum functional potential at this time. He can now transfer with SBA [stand by			

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	assistance] of 1 and a sliding board and to a bedside commode with SBA...and should have a power chair, home O.T. [occupational therapy] home evaluation for home environment. D/C [discharge] recommendations wheelchair BSC [bedside commode] sliding board, hospital bed." A record review on 05-16-13 at 10:00 a.m., titled "Interdisciplinary Team Discharge Summary, dated 03-19-13, indicated the resident received skilled nursing observation and/or treatment and rehabilitative care. The section titled "nursing services indicated "none" for the area specific to "special treatments or procedures planned for discharge." A subsequent handwritten notation on "side two" of this "Interdisciplinary Discharge Summary," indicated "D/C'd [discharged] to [name of local area hotel] on 03-14-13 (sic) Anderson Indiana. Hotel couldn't meet needs. He readmitted on 03-14-13 (sic) and discharged on 03-22-13 to apartment complex named [name of apartment complex]. "VA [veterans administration] benefits, Home Healthcare in place upon discharge. [Name of ambulance company] to transport			

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	resident back home. [Name of area home health agency] will be the home care company." On 05-16-13 at 12:37 p.m., the Director of Nurses for the Home Health Agency was interviewed and indicated the following: "The whole thing was a mess. He originally lived on the fourth floor of the apartment complex. He needed to use the freight elevator to get from the ground floor to his apartment. When the freight elevator had not been repaired, they [employees at the apartment complex] decided to put him at [name of local area motel]. When he was released all they [the facility] did was tell them [apartment] he was going to be discharged and the lady at the [name of motel] was told he needed a handicapped accessible room. Supposedly he was only to be there over a weekend. He needed a bariatric bed, a trapeze, siderails and other things a new amputee needs. When I called the motel they told me they couldn't get him or the wheelchair through the front door or any other door at the motel. He called to tell me what was going on and my understanding is that the ambulance crew took him to [name of local area hospital]. The			

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	hospital couldn't keep him so they took him back to Manor Care in Carmel. When I talked to them [at the facility] I told them the next time you guys release him make sure that when he comes home he can function and maneuver around the apartment, he is not mobile and if there had been a fire he would be history. They got him up to his apartment and they had to put him in his recliner because his wheelchair was too wide to get through the bedroom or bathroom doorway. You don't just throw someone in an apartment. He had a urinal next to the recliner, but if he had a bowel movement, he couldn't get out of the recliner to take care of himself. When they discharged him they never even sent us orders. The nursing home just didn't do their part." A review of the "Home Health Nursing Visit Record," dated 03-22-13 after the resident was discharged a second time from the facility, indicated the following "skilled intervention" nurses note: "Had left BKA [below the knee amputation] at Indy VA, then spent time at ECF [extended care facility] for Rehab. [rehabilitation]. Able to use urinals next recliner in living room. Confined to living room due to wheelchair is 40 inches wide and doorways only 36 inches. Currently			

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	wearing adult brief in case bowels have to move. Has no prosthetic for left leg and is unable to use walker. Comfortable in recliner and has items he may need within reach. Phone and emergency button within reach. Has friend upstairs if he needs something minor. Glad to be home but unhappy he's unable to go thru doorways and is confined to living room at this time." A subsequent notation, dated 03-24-13 indicated the resident was unable to do "board transfers and stays in his chair." Review of the job description for Social Worker on 05-17-13 at 8:30 a.m., indicated the following: "Job Summary - Responsible to provide medically related social work services so that each resident/patient may attain or maintain the highest practicable level of physical, mental and psychosocial well-being." "Social Worker Responsibilities - Communicates effectively with the interdisciplinary team, resident/patients, families, and community agencies. Makes appropriate referrals to other consultants, community agencies or Center departments in order to facilitate the resident's/patient's			

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	maximum use of resources, and to promote the resident/patients increased level of social functioning." Review of a packet of information on 05-17-13 at 11:30 a.m., provided by the facility Social Worker, in regard to the facility "team approach to discharge planning," indicated the following: "The way a patient moves from a facility to the post discharge environment leaves a lasting impression." "A well planned discharge boosts patient and family confidence, increases patient safety, and gives the staff a sense of accomplishment. Focusing on patients being completely prepared to manage their care following discharge defines a successful discharge strategy." "Social services had the responsibility to act as a patient advocate. This involves: understanding the patient's expectations about returning to the post discharge environment, talking with the patient about the discharge date, focusing the patient on the overall goal of being completely prepared to manage care following discharge, communicating on the			

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	patient's behalf with the team and community resources to keep the patient's options flexible, evaluating the patient's post discharge care and service needs, setting up needed community resources to the patient has support in the post discharge environment." "Think strategically about anticipated discharges and bring structure to the way they are planned. This helps minimize last minute notifications and the patient benefits from the smooth transition." Interview on 05-17-13 at 9:00 a.m., the Administrator indicated the person who was mainly responsibility to ensure a safe and orderly transfer of a resident was "the Social Worker." This Federal tag relates to Complaint IN00126860. 3.1-34(a)			

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F000406 SS=G	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.			
	Based on record review and interview the facility failed to ensure the necessary care and services for a resident to maintain the highest practicable physical, mental and psychosocial well being in regard to a safe and orderly discharge from the facility, in that when a resident who was unable to ambulate/transfer and required ancillary services at the time of discharge, which included durable medical equipment and coordination of services with other agencies, to include occupational therapy and nursing services, the facility failed to take appropriate steps for the discharge of 1 of 1 resident reviewed for discharge and who had special needs which resulted in a resident confined to one area of the home and defecating on self due to inability to transfer from a recliner in a sample 5.	F000406	**F 406 SS=G Provide/Obtain Specialized Rehab Services** It is the practice of this center to comply with F 406 Provide/Obtain Specialized Rehab Services. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # A No longer resides at the Facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Residents that have diagnosis that require special needs and coordination of services with other agencies as part of their discharge plans have the potential to be affected and have been reviewed for appropriate discharge planning related to assistive devices, equipment needs, and documentation that	06/14/2013

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	(Resident "A"). Findings include: The record for Resident "A" was reviewed on 05-16-13 at 9:41 a.m. Diagnoses included but were not limited to obesity, deep vein thrombosis, diabetes mellitus, atrial fibrillation and a recent below the knee amputation. The resident weighed 524 lbs. at the time of discharge These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 12-19-12 after surgery which included a left below the knee amputation. A review of the resident's plan of care, originally dated 12-24-12 indicated the "patient shows potential for discharge and patient expresses wish for discharge." The "goal" for this focus indicated, "Will be discharged to home when clinical and rehabilitation goals are met." "Interventions" included "Assess future placement setting to determine if resident's needs can be met, discuss with patient, family, and/or representative the discharge planning process, investigate need for special		services are coordinated to ensure a safe discharge. Observations will be recorded on the QAA monitoring tool and corrections will be completed by Administrative Director of Nursing Services/Designee and Director of Rehabilitation/Designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Therapy staff has been in-serviced by the Director of Rehabilitation on the Discharge Environment Observation Checklist/Assessment, and the Home Floor Plan Questionnaire. IDT has been in-serviced on accurate completion of the interdisciplinary team discharge summary form. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** Monitoring of residents with discharge orders will be conducted 5 times weekly x 12 weeks, then monthly x 3 months by the Director of Rehabilitation/Designee and validated by the Administrator/designee to ensure that the appropriate evaluations were completed which address resident needs to ensure a safe discharge and that documentation is in place according to the facility guidelines. Identified concerns shall be reviewed by the facility's	

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	equipment, home health physician follow up, and make referrals as needed." Review of the resident's Minimum Data Set Assessment, dated 02-14-13 indicated the resident was not able to move "on/off the toilet" or "surface to surface transfer" without the assistance of another person. The assessment also indicated the resident was "frequently incontinent of bowel and bladder, and required extensive assistance with transfer and bed mobility." A review of a "Local Mental and Behavioral Health Visit Note," dated 02-15-13 indicated the resident "is concerned that rehab. [rehabilitation] has ended sooner than he expected and he will be discharged when he does not feel prepared. He stated the accommodation to his home are not complete, as well as having worries about his continued healing process. Pt. [patient] has experienced a significant physical impairment that he was not prepared for. He has adjusted well, but he is now faced with the reality that he will be discharged back to him home. Recommendations for staff - Keep pt. informed of tx. [treatment] and d/c [discharge] planning to reduce worry."		QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance. **By what date the systemic changes will be completed?** June 14 th , 2013	

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	The resident was originally discharged from the facility on 03-19-13 after the completion of therapy services and wound care, and subsequently returned to the facility the same date due to inadequate discharge planning. Review of the physician "Progress Note," dated -3-19-13 indicated "Pt. [patient] apparently discharging today to hotel [home]." A review of the State Form "Notice of Transfer or Discharge," dated 03-19-13 indicated the resident was "being transferred to a private residence." Interview on 05-16-13 at 11:00 a.m., the Social Service Director indicated in regard to the resident transfer "The freight elevator [at the apartment complex] was going to be out of service for 30 days and when therapy ended the apartment complex said they would put him up at a hotel until the freight elevator was repaired. He couldn't fit through the door [at the hotel] because it wasn't handicapped accessible. We depended on the apartment complex since he couldn't go back home and they were paying for it. When the situation at the hotel			

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	wasn't working out, the ambulance took him to [name of hospital] but they couldn't keep him so they brought him back here. He came back to us and actually went back into the same room. Shortly after he returned to us we received a call the the freight elevator was fixed and he could return home to his apartment. When the ambulance service came here to pick him up they actually called the apartment complex to make sure they didn't run in to the same problem as before. The Home Health agency didn't come out and evaluate him because they are in a different county. He had a bariatric bed in his apartment and I thought all his needs were set up. I don't know about a bed side commode or a sliding board. I don't know how his bathroom was set up, but the amputation was new for him. As far as I know we didn't send orders to the Home Health Agency and they didn't ask for one." Interview on 05-16-13 at 1:15 p.m., the Therapy Director indicated, "We discharged him from therapies the middle of February [02-13-13]. He met his goals with us, but still had a skilled need with his amputation." When interviewed if anyone in therapy does a home evaluation prior			

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	to the discharge of a resident, the Therapy Director indicated, "We generally work off the 'floor plan.' We'll go if there seems to be a problem, but if we do, we assess the resident's ability to get around the apartment/home, not the apartment/home itself. I would say that, if for example we discharged twenty residents a month we might go to the home for one resident. At the time [name of resident] was discharged from therapy we didn't know where he was going. It wasn't until afterwards that we found out he was going to a hotel because of the broken freight elevator." Review of the "Occupational Therapy Summary," dated 02-13-13 indicated "Patient reached maximum functional potential at this time. He can now transfer with SBA [stand by assistance] of 1 and a sliding board and to a bedside commode with SBA...and should have a power chair, home O.T. [occupational therapy] home evaluation for home environment. D/C [discharge] recommendations wheelchair BSC [bedside commode] sliding board, hospital bed." A record review on 05-16-13 at 10:00 a.m., titled "Interdisciplinary Team			

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	Discharge Summary, dated 03-19-13, indicated the resident received skilled nursing observation and/or treatment and rehabilitative care. The section titled "nursing services" indicated "none" for the area specific to "special treatments or procedures planned for discharge." A subsequent handwritten notation on "side two" of this "Interdisciplinary Discharge Summary," indicated "D/C'd [discharged] to [name of local area hotel] on 03-14-13 (sic) Anderson Indiana. Hotel couldn't meet needs. He readmitted on 03-14-13 (sic) and discharged on 03-22-13 to apartment complex named [name of apartment complex]." "VA [veterans administration] benefits, Home Healthcare in place upon discharge. [Name of ambulance company] to transport resident back home. [Name of area home health agency] will be the home care company." On 05-16-13 at 12:37 p.m., the Director of Nurses for the Home Health Agency was interviewed and indicated the following: "The whole thing was a mess. He originally lived on the fourth floor of the apartment complex. He needed			

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	to use the freight elevator to get from the ground floor to his apartment. When the freight elevator had not been repaired, they [employees at the apartment complex] decided to put him at [name of local area motel]. When he was released all they [the facility] did was tell them [apartment] he was going to be discharged and the lady at the [name of motel] was told he needed a handicapped accessible room. Supposedly he was only to be there over a weekend. He needed a bariatric bed, a trapeze, siderails and other things a new amputee needs. When I called the motel they told me they couldn't get him or the wheelchair through the front door or any other door at the motel. He [the resident] called to tell me what was going on and my understanding is that the ambulance crew took him to [name of local area hospital]. The hospital couldn't keep him so they took him back to Manor Care in Carmel. When I talked to them [at the facility] I told them the next time you guys release him make sure that when he comes home he can function and maneuver around the apartment, he is not mobile and if there had been a fire he would be history. They [ambulance crew] got him up to his apartment and they had to put him in his recliner because his			

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	wheelchair was too wide to get through the bedroom or bathroom doorway. You don't just throw someone in an apartment. He had a urinal next to the recliner, but if he had a bowel movement, he couldn't get out of the recliner to take care of himself. When they discharged him they never even sent us orders. The nursing home just didn't do their part." During interview on 05-17-13 at 12:00 p.m., the Director of Nurses indicated that at the time of the resident "first" discharge, the resident was "picked up from the facility at 1:30 p.m., left the [name of the motel] at 4:22 p.m., left [name of the local area hospital] at 6:30 p.m., and returned to ManorCare at 8:35 p.m." A review of the "Home Health Nursing Visit Record," dated 03-22-13 after the resident was discharged a second time from the facility, indicated the following "skilled intervention" nurses note: "Had left BKA [below the knee amputation] at Indy VA, then spent time at ECF [extended care facility] for Rehab. [rehabilitation]. Able to use urinals next recliner in living room. Confined to living room due to wheelchair is 40 inches wide and doorways only 36 inches. Currently wearing adult brief in case bowels			

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	have to move. Has no prosthetic for left leg and is unable to use walker. Comfortable in recliner and has items he may need within reach. Phone and emergency button within reach. Has friend upstairs if he needs something minor. Glad to be home but unhappy he's unable to go thru doorways and is confined to living room at this time." A subsequent notation, dated 03-24-13 indicated the resident was unable to do "board transfers and stays in his chair." Review of a packet of information on 05-17-13 at 11:30 a.m., provided by the facility Social Worker, in regard to the facility "team approach to discharge planning," indicated the following: "The way a patient moves from a facility to the post discharge environment leaves a lasting impression." "The interdisciplinary team process is organized around the patient's expectations and needs. The team's goal is to work cooperatively with the patient to create a discharge plan that: * Results in a stable clinical and functional status pre-discharge, *Supports the patient's success in the post discharge environment,			

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	*Minimizes the possibility of re-hospitalization within 30 days after discharge from the SNF [skilled nursing facility]. For the goal to be realized the interdisciplinary team members need to actively support each other as the patient moves toward a successful outcome." "A well planned discharge boosts patient and family confidence, increases patient safety, and gives the staff a sense of accomplishment. Focusing on patients being completely prepared to manage their care following discharge defines a successful discharge strategy." "Each interdisciplinary team member has an equally important role in the discharge planning process and contributes to the patient being completely prepared at discharge." "Rehabilitation Services is responsible to restore the patient's functioning to the highest practicable level. Ideally this is the level at which the patient functioned before the event that resulted in hospitalization. It is also the functioning level that will allow the patient to physically manage daily needs in the post discharge environment. Determining needed home adaptations and equipment is			

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	another Rehab. [Rehabilitation] concern. Therefore it is important to know the patient's post discharge environment and the obstacles the patient needs to learn to navigate." "Social services has the responsibility to act as a patient advocate. This involves: understanding the patient's expectations about returning to the post discharge environment, talking with the patient about the discharge date, focusing the patient on the overall goal of being completely prepared to manage care following discharge, communicating on the patient's behalf with the team and community resources to keep the patient's options flexible, evaluating the patient's post discharge care and service needs, setting up needed community resources to the patient has support in the post discharge environment." "The Administrator monitors the team's process and ensures everyone is playing their part to benefit the patient." "Think strategically about anticipated discharges and bring structure to the way they are planned. This helps minimize last minute notifications and the patient benefits from the smooth			

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	transition." This Federal tag relates to Complaint IN00126860. 3.1-23(a)(2)			

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F000425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview the facility failed to ensure accurate reconciliation of controlled medications, in that when a resident was discharged from the facility with a three day supply of medications, which included narcotics, the nursing staff failed to reconcile the return of medications for 1 of 1 resident who was discharged and returned to the facility the same day in a sample of 5. (Resident "A"). Findings include: The record for Resident "A" was	F000425	**F 425 SS=D Pharmaceutical SVC-Accurate Procedures, RPH** It is the practice of this center to comply with F 425 Pharmaceutical SVC-Accurate Procedures, RPH **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # A No longer resides at the Facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Current newly admitted/readmitted	06/14/2013

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	reviewed on 05-16-13 at 9:41 a.m. Diagnoses included but were not limited to obesity, deep vein thrombosis, diabetes mellitus, atrial fibrillation and a recent below the knee amputation. The resident weighed 524 lbs. at the time of discharge. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 12-19-12 after surgery which included a left below the knee amputation. The resident was originally discharged from the facility on 03-19-13 after the completion of therapy services and wound care, and subsequently returned to the facility the same date due to inadequate discharge planning. Review of the physician "Progress Note," dated 03-19-13 indicated "Pt. [patient] apparently discharging today to hotel [home]." A review of the State Form "Notice of Transfer or Discharge," dated 03-19-13 indicated the resident was "being transferred to a private residence."		residents residing at the facility with orders for narcotics have the potential to be affected, and have been reviewed to ensure narcotics have been reconciled according to facility guideline. Observations will be recorded on the QAA monitoring tool and corrections will be completed by the Administrative Director of Nursing/Designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Licensed Nurses have been in-serviced by the Administrative Director of Nursing/Designee on the facility Narcotic Count Guideline. Nursing staff have been in-serviced on the Admission/Readmission Process for inventory of resident belongings. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** Monitoring of newly admitted/readmitted resident charts will be conducted 5 times weekly x 12 weeks, then monthly x 3 months by the Administrative Director of Nursing/Designee to ensure compliance with the facility narcotic count guideline and to ensure an inventory of belongings was completed for admissions. Identified concerns shall be reviewed by the facility's QAA Committee.	

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	The clinical record indicated at the time of discharge on 03-19-13 the resident was "sent" home with medications, which included Oxycodone HCL-Acet. (a narcotic analgesic) 5/325 and 10/325 tablets. Review of the "Controlled Substances Records," indicated at the time of discharge the resident left the facility with 15 tablets '(5/325 dosage) and 22 tablets (10/325 dosage). Interview on 05-16-13 at 11:00 a.m., the Social Service Director indicated in regard to the resident discharge "[Name of resident] was unable to return to his apartment because he needed to use the freight elevator to get to his apartment so the people at the apartment complex arranged for him to go to a motel. He couldn't fit through the door [at the hotel] because it wasn't handicapped accessible. The ambulance took him to [name of local area hospital] and they couldn't keep him so they brought him back here." Further review of the clinical record on 05-17-13 at 10:00 a.m., lacked documentation of the return or destruction of the controlled medications or even if the resident returned to the facility with the controlled medications.		Recommendations for further corrective action will be discussed and implemented to sustain compliance **By what date the systemic changes will be completed?** June 14 th , 2013	

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	Interview on 05-17-13 at 12:00 p.m., the Director of Nurses indicated the resident left the facility at 1:30 p.m. on 03-14-13, and returned to the facility the same day at 8:35 p.m. The Director of Nurses indicated she hadn't thought about the return of the controlled medications, and had no documentation to indicate how the licensed nurses handled the return or if the medications were returned when the resident re-admitted to the facility. In addition the record lacked any documentation in regard to the narcotic analgesic. This Federal tag relates to Complaint IN00126860. 3.1-25(b)			