STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR HEALTHCARE	2926 N CAPITOL AVE INDIANAPOLIS, IN 46208

(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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 5, 7, 8 & 13, 2012 Facility number: 000567 Provider number: 155711 AIM number: 100289560 Survey team: Diana Zgonc RN TC Connie Landman RN Christi Davidson RN Lori Brettnacher RN Census bed type: SNF: 1 SNF/NF: 28 NF: 12 Total: 41 Census payor type: Medicare: 2 Medicaid 39 Total: 41 These deficiencies reflect state findings cited in accordance it 410 IAC 16.2. Quality review completed 11/15/12 Cathy Emswiller RN	F0000	Please accept this plan of correction as our credible allegation of compliance. Preparation and execution of correction in general, or this corrective action in particular does not constitute an admission or agreement by Highland Manor Healthcare of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and / or executed in compliance with Federal and State laws.	

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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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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. Based on observation, record review and interview the facility failed to ensure residents were provided activities in the evening for 2 of 3 residents reviewed for activities. (#41, #11) Findings include: 1. The record for Resident #41 was reviewed on 11/07/12 at 2:05 p.m. Diagnoses included but were not limited to decubitus ulcers, anemia, paraplegia and muscle spasms. The most recent quarterly Minimum Data Set [MDS] assessment dated 8/21/12 indicated Resident #41 was assessed a 15 out of a possible 15 for cognition which indicated Resident #41 reported the correct year, correct month and correct day of the week and recalled 3 of 3 words without cueing. The MDS indicated Resident #41 was independent for bed mobility and transfers. The MDS indicated	F0248	All residents have the potential to be affected. The corrective action taken includes: Derived from interviews of patients #41 and #11 and the most recent patient assessments, Activites that would be appropriate for evenings have been scheduled. Volunteers and staff have agreed to trade off working the evening activities. The remaining November Activities Schedule has been updated indicating the evening activities and has been distributed to patients, staff, and interested families. The main activities calendar in the activities area has been updated. Monthly resident/family counsel agenda will include suggestions for evening activities as will initial resident activity preference interviews. Activities Director will review monthly with Administrator the Activities Calendar prior to publication. QA will review for three months then quarterly thereafter. Activities Director is responsible. Attachment A - Activities	11/14/2012

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	Resident #41 had bilateral lower extremity impairment. During an observation on 11/07/12 at 1:02 p.m., a large activity calendar with activities listed for November 2012 was located on the wall in the designated activity area adjacent to the main dining area. The activity calendar indicated the latest daily activity available was scheduled at 4:15 p.m. During an interview on 11/05/2012 at 10:29 a.m., Resident #41 indicated there were not activities offered in the evening. Resident #41 indicated, "they smoke and then go to bed." During an interview on 11/7/12 at 3:20 p.m., Resident #41 indicated there were no organized activities in the evening. Resident #41 indicated, "There is no one here to do the activities." Resident #41 indicated there was not access to movies or cards, unless the residents own their own cards. Resident #41 indicated, "It is dead" after dinner. Resident #41 indicated dinner was served at 6 p.m.		Calendar Nov. 2012	

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	2. Resident #11's record was reviewed on 11/07/2012 at 1:06 P.M. Resident #11 was admitted to the facility on 8/23/2010 and readmitted on 4/7/2012. She had current diagnoses which included but were not limited to diabetes type II, multiple sclerosis, hypertension, asthma, osteoarthritis, anemia, congestive heart failure, and chronic pain. Resident #11 had a current physician activity order which indicated she could be up in a wheel chair as tolerated. During an interview on 11/5/2012 at 2:06 P.M., Resident #11 indicated there were no activities available in the evenings and not a lot going on during the weekends. She indicated she would like more to do. An activities evaluation note dated 8/23/2012 indicated Resident #11 loved bingo and manicures. She was assessed to enjoy bingo, family/friend visits, movies and manicures. She was cooperative, motivated, interested. She had a good long and short term memory and was oriented to person, place, and time. An annual minimum data set			

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	assessment (MDS) dated August 21, 2012 indicated Resident #11 preferences for customary routines and activities included: listening to music (somewhat important), keeping up with the news (very important), doing things with groups of people (very important), doing favorite activities (very important), spending time outside (very important), and participating in religious services (very important). This MDS indicated Resident #11 was dependant on staff for transfers and bed mobility. The resident was able to report the correct year, month and day but could only recall 1 of 3 words after 5 minutes. Review of the November activity calendar indicated the latest daily activity started at 3:30 P.M. or 4:15 P.M. During an interview on 11/8/2012 at 2:30 P.M., The Activity Director stated, " To tell you the truth, they may have an activity in the evenings once a month and it is usually a movie the nurses set that up or a church group will come in. There were no evening activities in August, September, or October. The help I have can not work past 4:00 P.M. When I first started a year ago I use to come in			

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	early and stay late but I was wearing myself out. I am working on trying to get volunteers in. Sometimes we have football games for the guys but it has been awhile." 3.1-33(c)			

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F0280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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.			
	Based on record review and interview the facility failed to ensure 3 residents were invited to participate in care planning conferences out of 24 residents reviewed for care plans. (#41, #11, #13) Findings include: 1. The record for Resident #41 was reviewed on 11/07/12 at 2:05 p.m. Diagnoses included but were not limited to decubitus ulcers, anemia, paraplegia and muscle spasms. The most recent quarterly Minimum	F0280	All residents have the potential to be affected. Corrective action was undertaken immediately on November 7th for resident #41 by inviting resident #41 and holding a care plan conference. Resident #11 had last care plan meeting on 10/31/12, although invited, she did not attend. A care plan meeting was held on 11/14/12 which resident #11 was invited and did attend and sign the attendance form. Resident #13 had last care plan meeting on 8/29/12 and did attend with resident #11. Resident #13 has a care plan meeting scheduled for 11/28/12 which both resident #13 and #11	11/14/2012

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	Data Set [MDS] assessment dated 8/21/12 indicated Resident #41 was assessed a 15 out of a possible 15 for cognition which indicated Resident #41 reported the correct year, correct month and correct day of the week and recalled 3 of 3 words without cueing. The MDS indicated Resident #41 was independent for bed mobility and transfers. The MDS indicated Resident #41 had bilateral lower extremity impairment. A document for Resident #41 titled, "Signature and Title of ICP [interdisciplinary care plan] Participants," indicated the last care plan conference signed by nursing, dietary, social service, activities, therapy, other discipline and Resident #41 was held 5/30/12. During an interview on 11/8/12 at 2:00 p.m., the DoN was asked to clarify if Resident #41's care plans had been updated, and if a care plan conference was held for Resident #41 since 5/30/12. During an interview on 11/8/12 at 3:00 p.m., the Social Service Director [SSD]indicated Resident #41's care plan conference was missed in August 2012. The SSD indicated, "We will do a care conference today."		have been invited. Corrective action: All residents and/or families will be invited to attend care plan conferences and will be asked to sign the attendance form. Social Services will document in Social Services note any resident or family invited yet did not attend. QA will monitor all care plan conference notes in the Social Services file for three months and then quarterly for three quarters to assure compliance. Social Services Director is responsible.	

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	During an interview on 11/8/12 at 3:13 p.m., the SSD indicated the signature page of the care plan conference reflects the date the care conference was held, and each care plan is supposed to be updated as there are changes made to the resident's plan of care. 2. Resident #11's record was reviewed on 11/07/2012 at 1:06 P.M. Resident #11 was admitted to the facility on 8/23/2010 and readmitted on 4/7/2012. She had current diagnoses which included but were not limited to diabetes type II, multiple sclerosis, hypertension, asthma, osteoarthritis, anemia, congestive heart failure, and chronic pain. An activities evaluation note dated 8/23/2012 indicated Resident #11 was cooperative, motivated, interested. She had a good long and short term memory and was oriented to person, place, and time. During an interview on 11/5/2012 at 2:08 P.M., Resident #11 was asked if she was invited to participate in her care plan meetings. She indicated she did not attend many of the care plan meetings because she was not invited.			

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	The care plan attendance signature sheet indicated from 9/21/2012 through 10/31/2012 there were 6 care plan conferences. Resident #11 attended three of them. During an interview on 11/8/2012 at 2:06 P.M., the Social Service Director indicated residents and family were invited to care plan meetings but she did not have any documentation residents or family were invited to the care plan meetings. She did not have documentation Resident #11 had been invited to all of the care plan meetings. 3. Resident #13's record was reviewed on 11/7/2012 at 2:44 P.M. Resident #13 was admitted on 8/23/10 and had current diagnoses which included but were not limited to Alzheimer's disease, senile dementia, and hypertension. His primary language was Spanish. He could speak and understand some English but his wife was his main translator, is a resident of the facility and in the same room. During a family interview on 11/5/2012 at 2:27 P.M., Resident #13's wife indicated she was not invited to his care plan meetings.			

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	She stated, "He doesn't understand English. They do not try to communicate with him other than through me." The care plan attendance signature sheet indicated from 9/21/2012 through 8/29/2012 there were five care plan conferences. Resident #13 and his wife attended one of the five meetings. During an interview on 11/8/2012 at 2:06 P.M., the Social Service Director indicated residents and family were invited to care plan meetings but she did not have any documentation residents or family were invited to the care plan meetings. She did not have documentation that Resident #13 and or his wife had been invited to all of the care plan meetings. 3.1-35(c)(2)(C)			

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F0282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure B/P's (blood pressures) were done prior to medication administration for 1 of 10 residents reviewed for B/P monitoring (Resident # 47), failed to ensure laboratory tests were done as ordered by the physician for 3 of 10 residents reviewed for laboratory testing (Residents # 10, #39, and # 37), and failed to ensure oral hygiene was provided to 1 of 3 residents reviewed for dental care (Resident # 11). Findings include: 1. The record for Resident # 47 was reviewed on 11/7/12 at 1:30 P.M. Current diagnoses included, but were not limited to, diabetes mellitus type 2, HTN (hypertension), coronary artery disease, substance abuse, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and depression. A health care plan, dated 9/11/12,	F0282	A. Labs All residents with monitoring lab orders have the potential to be affected. Resident #39 PT/INR lab order re-written and sent to lab immediately upon discovery. Weekly labs being done and monitored during weekly audit. Lab will be notified for draw if audit reveals missed draw. Resident #37 had lab scheduled for 11/12/12 which resident declined. MD did not re-order lab 'every month 3x - con't every 3 months.' Resident #10 lab order re-written for renewal 11/8/12 and was drawn 11/9/12. Draws being audited and missed labs will be re-ordered. All resident charts were reviewed for standing and/or additional lab orders. An audit was completed to ensure all ordered labs were scheduled and drawn and reports available for the chart. Daily and weekly audit will aid in tracking ordered labs, the completion and the availability. Expired lab orders have been rewritten and this will be monitored when re-writes of physician orders are done each month. Additionally, nurses will record drawn labs on	11/14/2012

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	indicated hypertension was a focus. Interventions for hypertension included, but were not limited to, medication as ordered, monitor B/P (blood pressure), and notify MD of SBP (systolic B/P) or DBP (diastolic B/P) elevations. A current physician's order, dated 9/14/12, indicated Carvedilol (anti-hypertensive medication)12.5 mg (milligrams) to be given twice a day, and to hold the medication if the SBP was less than 110. A current physician's order, dated 9/14/12, indicated Lisinopril (anti-hypertensive medication) 10 mg was to be given once a day, and to hold for SBP less than 110. The October and November, 2012, MARs (Medication Administration records) lacked documentation of any B/P's being taken prior to the administration of the Carvedilol or Lisinopril. During an interview with the DON (Director of Nursing) on 11/13/12 at 10:30 A.M., she indicated if she missed the order, everybody missed the order. After looking through Resident # 47's record at that time, the DON indicated the hold order had		resident TAR as well as write in one-time or new orders on the TAR. QA will review for three months, then quarterly three times. Nurses and Medical Records are responsible. DON will monitor. Attachment B - Lab Tracking Log B. B/P All residents requiring B/P monitoring have the potential to be affected. Resident #47 had BID B/P added to MAR. Initiated monitoring on 11/14/12. Added to 12/2012 MAR to ensure monitoring before administration of medication. Staff in-serviced. All resident charts were reviewed for BP monitoring to ensure all residents receiving BP medication are being monitored for changes in BP. Additionally, DON monitors/reviews new admits and will continue to perform this review to identify needed interventions for BP monitoring. This needed monitoring has been reviewed with all nurses responsible for tracking effect of medication on BP. This practice will be reviewed in QA for three months, then quarterly three times. Charge nurses are responsible. DON will monitor. Attachment C - Inservice on Tracking BP C. Oral Care All residents have the potential to be affected. Resident #11 had oral care done.	

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	been missed. 2. The record for Resident # 39 was reviewed on 11/7/12 at 3:01 P.M. Diagnoses for Resident # 39 included but were not limited to diabetes, epilepsy, deep vein thrombosis (blood clot), cerebral vascular accident stroke), chronic respiratory failure (tracheostomy), myocardial infarction (heart attack), chronic kidney disease, gastrostomy tube and neurogenic bladder. A current physician's order for November and originally dated		Oral assessment competed. Care being monitored and verified with resident for needed corrections. Staff in-serviced. Documentation of oral care has been reviewed with the CNAs. The performance of oral care is being monitored and addressed by the licensed nurse. An oral assessment has been completed on all residents by the charge nurses and those findings will be identified on the ADL sheets. Documentation of completed care will be indicated by a ¿ mark. Residents will be queried and follow up completed. QA will monitor and review for three months, then for three quarters. CNAs are responsible. Charge nurses to monitor. Attachment D - Inservice Oral Care	

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NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 N CAPITOL AVE INDIANAPOLIS, IN 46208	

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	10/13/12 indicated PT/INR (a laboratory [lab] test for anticoagulant use) to be done weekly. The record lacked documentation of the PT/INR lab test being completed the week of 10/15/12. 3. The record for Resident # 10 was reviewed on 11/7/12 at 2:33 P.M. Diagnoses for Resident # 10 included but were not limited to erosive gastropathy, chronic obstructive pulmonary disease, degenerative joint disease, gastroesophageal reflux disease, contractures, dementia with psychosis, gastrointestinal bleed from ulcer, hiatal hernia, edema and depression. A current physician's order for November and originally dated 2/18/12 indicated CBC & BMP (laboratory blood work) to be done every 6 months in April and October. The record lacked documentation of the CBC & BMP lab test being completed in October. 4. The record for Resident # 37 was reviewed on 11/8/12 at 1:16 P.M. Diagnoses for Resident # 37 included			

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	but were not limited to diverticulitis abscess, anemia, gastroesophageal reflux disease, diabetes, hypertension, anxiety, deep vein thrombosis, arthritis, hearing loss, dementia with confusion & delusional ideation. A current physician's order for November and originally dated 7/16/12 indicated BMP (laboratory blood work) to be done every month for 3 months. The record lacked documentation of the BMP lab test being completed in September. During an interview on 11/8/12 at 11:00 A.M., lab tests were requested for Resident # 39 & #10. During an interview with the Director of Nursing on 1/8/12 at 1:00 P.M., she indicated the labs were not done in October because they expired in September. We have to audit the charts for expiring labs. Our lab requires a new order each year and it was not caught in an audit. During an interview with the Director of Nursing on 1/8/12 at 3:00 P.M., she indicated there were no labs for the BMP for Resident # 37 for			

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	September. 5. Resident #11's record was reviewed on 11/07/2012 at 1:06 P.M. Resident #11 was admitted to the facility on 8/23/2010 and readmitted on 4/7/2012. She had current diagnoses which included but were not limited to diabetes type II, multiple sclerosis, hypertension, asthma, osteoarthritis, anemia, congestive heart failure, and chronic pain. An activities evaluation note dated 8/23/2012 indicated Resident #11 had a good long and short term memory and was oriented to person, place, and time. During an interview on 11/5/2012 at 2:15 P.M., Resident #11 was asked if staff helped her as necessary to clean her teeth. She replied, "Never. It has been a long time since they have helped me." Resident #11's Data Flow Sheets for October 2012 and November 1-6th, 2012 indicated Resident #11 had no teeth. During an observation on 11/5/2012 at 2:15 P.M. Resident #11 showed her mouth which contained no upper teeth and several bottom teeth.			

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	An annual minimum data set assessment (MDS) dated 8/21/2012 indicated Resident # 11 required extensive assist of one staff member for personal hygiene and had obvious or likely cavities or broken or missing natural teeth. A current care plan originally dated 11/5/11 and last updated 10/31/2012 indicated Resident #11 had a need for dressing and grooming. A goal for Resident #11 included she would be able to perform oral care. An intervention listed to meet this goal included provide assistance where needed. During an interview on 11/13/2012 at 1:20 P.M., The Director of Nursing was asked to provide documentation oral care had been provided for Resident #11. Documentation for the month of October 2012 on the Activities of Daily Living flow sheets indicated Resident #11 did not have any teeth. During an interview on 11/13/2012 at 1:52 P.M. the DON stated, "I just asked the aide who is caring for her today and she said she had no teeth." The DON was informed Resident #11			

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	was observed to have bottom teeth. She indicated she would do an oral assessment herself. She did not have documentation the care was provided. During an interview on 11/8/2012 at 3:00 P.M., The Social Service Director stated, "We don't offer routine dental care. We use to but we were handing out $60.00 a month for them to come in and say they don't have teeth. Unless there is complaints of pain or something unusual then we will send them to a dentist. Nursing will notify me or I will notify nursing." At this time documentation of the last time Resident #11 saw a dentist was requested. 3.1-35(g)(2)			

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F0309 SS=D	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. Based on record review and interview, the facility failed to ensure B/P monitoring was done for 1 of 10 residents reviewed for medication monitoring (Resident # 47). Findings include: 1. The record for Resident # 47 was reviewed on 11/7/12 at 1:30 P.M. Current diagnoses included, but were not limited to, diabetes mellitus type 2, HTN (hypertension), coronary artery disease, substance abuse, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and depression. A health care plan, dated 9/11/12, indicated hypertension was a focus. Interventions for hypertension included, but were not limited to, medication as ordered, monitor B/P (blood pressure), and notify MD of SBP (systolic B/P) or DBP (diastolic B/P) elevations.	F0309	All residents requiring B/P monitoring have the potential to be affected. Resident #47 had BID B/P added to MAR. Initiated monitoring on 11/14/12. Added to 12/2012 MAR to ensure monitoring before administration of medication. Staff in-serviced. All resident charts were reviewed for BP monitoring to ensure all residents receiving BP medication are being monitored for changes in BP. Additionally, DON monitors/reviews new admits and will continue to perform this review to identify needed interventions for BP monitoring. This needed monitoring has been reviewed with all nurses responsibly for tracking effect of medication on BP. This practice will be reviewed in QA for three months, then quarterly three times. Charge nurses are responsible. DON will monitor. Attachment C	11/14/2012

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	A current physician's order, dated 9/14/12, indicated Carvedilol (anti-hypertensive medication)12.5 mg (milligrams) to be given twice a day, and to hold the medication if the SBP was less than 110. A current physician's order, dated 9/14/12, indicated Lisinopril (anti-hypertensive medication) 10 mg was to be given once a day, and to hold for SBP less than 110. The October and November, 2012, MARs (Medication Administration records) lacked documentation of any B/P's being taken prior to the administration of the Carvedilol or Lisinopril. During an interview with the DON (Director of Nursing) on 11/13/12 at 10:30 A.M., she indicated if she missed the order, everybody missed the order. After looking through Resident # 47's record at that time, the DON indicated the hold order had been missed. 3.1-37(a)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview the facility failed to ensure physician ordered laboratory (lab) tests were completed for 3 of 3 residents reviewed for lab tests (Resident # 39, #10, #37). 1. The record for Resident # 39 was reviewed on 11/7/12 at 3:01 P.M. Diagnoses for Resident # 39 included but were not limited to diabetes, epilepsy, deep vein thrombosis (blood	F0329	All residents with monitoring lab orders have the potential to be affected. Resident #39 PT/INR lab order re-written and sent to lab immediately upon discovery. Weekly labs being done and monitored during weekly audit. Lab will be notified for draw if audit reveals missed draw. Resident #37 had lab scheduled for 11/12/12 which resident declined. MD did not re-order lab 'every month 3x - con't every 3 months.' Resident #10 lab order re-written	11/14/2012

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	clot), cerebral vascular accident stroke), chronic respiratory failure (tracheostomy), myocardial infarction (heart attack), chronic kidney disease, gastrostomy tube and neurogenic bladder. A current physician's order for November and originally dated 10/13/12 indicated PT/INR (a laboratory [lab] test for anticoagulant use) to be done weekly. The record lacked documentation of the PT/INR lab test being completed the week of 10/15/12. 2. The record for Resident # 10 was reviewed on 11/7/12 at 2:33 P.M. Diagnoses for Resident # 10 included but were not limited to erosive gastropathy, chronic obstructive pulmonary disease, degenerative joint disease, gastroesophageal reflux disease, contractures, dementia with psychosis, gastrointestinal bleed from ulcer, hiatal hernia, edema and depression. A current physician's order for November and originally dated 2/18/12 indicated CBC & BMP (laboratory blood work) to be done every 6 months in April and October.		for renewal 11/8/12 and was drawn 11/9/12. Draws being audited and missed labs will be re-ordered. All resident charts were reviewed for standing and/or additional lab orders. An audit was completed to ensure all ordered labs were scheduled and drawn and reports available for the chart. Daily and weekly audit will aid in tracking ordered labs, the completion and the availability. Expired lab orders have been rewritten and this will be monitored when re-writes of physician orders are done each month. Additionally, nurses will record drawn labs on resident TAR as well as write in one-time or new orders on the TAR. QA will review for three months, then quarterly three times. Nurses and Medical Records are responsible. DON will monitor. Attachment B	

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	The record lacked documentation of the CBC & BMP lab test being completed in October. 3. The record for Resident # 37 was reviewed on 11/8/12 at 1:16 P.M. Diagnoses for Resident # 37 included but were not limited to diverticulitis abscess, anemia, gastroesophageal reflux disease, diabetes, hypertension, anxiety, deep vein thrombosis, arthritis, hearing loss, dementia with confusion & delusional ideation. A current physician's order for November and originally dated 7/16/12 indicated BMP (laboratory blood work) to be done every month for 3 months. The record lacked documentation of the BMP lab test being completed in September. During an interview on 11/8/12 at 11:00 A.M., lab tests were requested for Resident # 39 & #10. During an interview with the Director of Nursing on 1/8/12 at 1:00 P.M., she indicated the labs were not done in October because they expired in			

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	September. We have to audit the charts for expiring labs. Our lab requires a new order each year and it was not caught in an audit. During an interview with the Director of Nursing on 1/8/12 at 3:00 P.M., she indicated there were no labs for the BMP for Resident # 37 for September. 3.1-48(a)(3)			

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F0334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on record review and interview, the facility failed to ensure annual education was given and consents obtained prior to the administration of the annual influenza vaccinations for 4 of 5 residents reviewed for annual consents and education for flu vaccines (Residents #28, # 17, # 4, and # 29). Findings include: 1. The record for Resident # 28 was reviewed on 11/7/12 at 2:30 P.M. Resident # 28 received the flu	F0334	All residents have the potential to be affected. All immunizations have been administered to current residents this year. All residents signed new consent/education and/or sent to guardians for signatures on 11/14/2012. New residents are offered immunization consent and education upon admission. Corrective action done by revising policy to direct Social Services and/or Nursing to have consent and education on immunizations done annually in July, or upon pharmacy notification of request for pre-order, for all current residents. Medical Records will audit all current charts to confirm	11/14/2012

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	vaccine on 10/1/12. The last consent and education documented in the record was dated 8/11/10. 2. The record for Resident # 17 was reviewed on 11/7/12 at 2:35 P.M. Resident # 17 received the annual flu vaccine on 10/1/12. The last consent and education in the record was signed 7/23/10. 3. The record for Resident # 4 was reviewed on 11/7/12 at 2:40 P.M. Resident # 4 received the flu vaccine on 10/1/12. The last consent and education documented was on 8/11/10. 4. The record for Resident # 29 was reviewed on 11/7/12 at 2:50 P.M. Resident # 29 received the annual flu vaccine on 10/1/12. The last consent and education documented in the record was on 9/24/10. During an interview on 11/7/12 at 3:30 P.M., the Social Services Director indicated once the consents were signed, they were put in the charts, but the consents and educations were only done once, not annually.		consent is current in September annually. Policy attached - E QA will monitor annually in September. Social Services is responsible for compliance.	

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	Interview with SSD, 11/7/12, current flu and pneumonia consents are in the records. Once they are signed, they are done, we don't do them annually. A current facility policy, dated 8/2/10, titled "Vaccinations", provided by the DON (Director of Nursing) on 11/5/12 at 10:00 A.M., indicated: "... Procedure: The facility will provide the prescribed vaccines with a physician's order and signed consent. Consent forms to be signed on admission for future reference...." 3.1-13(a)			

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HIGHLAND MANOR HEALTHCARE	2926 N CAPITOL AVE INDIANAPOLIS, IN 46208

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure a resident's nourishment/snack refrigerator was kept sanitary with opened food dated and labeled and with a thermometer present in the refrigerator for 1 of 1 facility nourishment/snack refrigerator. This had the potential to affect 39 of 41 residents who received food stored and prepared in the facility. Findings During an interview on 11/5/2012 at 1:15 P.M., LPN (Licensed Practical Nurse) #3 indicated the refrigerator at the nurse's station was for resident use. With LPN #3 present observation of the refrigerator contents revealed: Eleven sandwiches in wrap not dated or marked with a resident name. LPN #3 indicated she did not have a way to know how long they had been in there. The bread was hard to touch. A carton of opened milk not dated or	F0371	All resident have the potential to be affected. Director of Nursing cleaned refrigerator upon learning of its condition. DON placed a new thermometer in refrigerator. Evening cleaning crew added this refrigerator to daily schedule. It is company policy that all refrigerators must have food labeled and dated. Each refrigerator must also have a temperature log. Dietary staff will monitor daily and update log when placing snacks and health shakes in refrigerator. Administrator will monitor daily in morning tour. Dietary is responsible.	11/14/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 N CAPITOL AVE INDIANAPOLIS, IN 46208	

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	labeled with a resident name. A plate of food covered with foil not marked with a resident name or dated. LPN#3 indicated it probably was brought in by a family member. A plate of food in a plastic bag stuck to the bottom of the refrigerator not dated or tabled with a resident's name. A opened plastic container of cookies without a date or name. Another plastic bag of opened cookies without a name or date. A yellow substance spilled on the bottom and side shelves. No thermometer. LPN #3 indicated it use to be in there but it must have fallen out. She indicated they keep the milk in the refrigerator along with the health shakes for diabetic patients. No temperature logs were available. During an observation on 11/7/2012 at 3:57 P.M. the nourishment/snack refrigerator was observed to contain juice containers, health shakes, and an opened milk container. The yellow substance remained all over the bottom of and the inside shelves of the refrigerator. A bug flew out when the door was opened. The refrigerator did not have a thermometer. 3.1-21(i)(3)			

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F0412 SS=E	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.			
	Based on observation, record review, and interview, the facility failed to provide routine dental services for 3 of 3 residents reviewed for dental care (Resident #11, Resident #13, and Resident #27). Findings Resident #11 1. Resident #11's record was reviewed on 11/07/2012 at 1:06 P.M. Resident #11 was admitted to the facility on 8/23/2010 and readmitted on 4/7/2012. She had current diagnoses which included but were not limited to diabetes type II, multiple sclerosis, hypertension, asthma, osteoarthritis, anemia, congestive heart failure, and chronic pain. Resident currently received medicaid services.	F0412	All residents have the potential to be affected. Resident #13 is currently being followed by a dentist and had an appointment on 11/2/12 and a follow up on 12/6/12. Resident #11 has a dentist appointment scheduled for 12/3/12. Resident #27 has a dentist appointment scheduled for 11/29/12. All residents records audited for last Dentist encounter. Those residents with Dentist contact outside of a year where compiled. A mobile dentist company that accepts Medicaid has been contacted and is scheduled to be at the facility on 12/13/2012 to see all other residents. QA will monitor for three months, then for three quarters. Social Service Director is responsible.	12/06/2012

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	An activities evaluation note dated 8/23/2012 indicated Resident #11 had a good long and short term memory and was oriented to person, place, and time. During an interview on 11/5/2012 at 2:15 P.M., Resident #11 was asked if staff helped her as necessary to clean her teeth. She replied, "Never. It has been a long time since they have helped me." She indicated she had not been seen by the dentist. Resident #11's Data Flow Sheets for October 2012 and November 1-6th, 2012 indicated Resident #11 had no teeth. During an observation on 11/5/2012 at 2:15 P.M. Resident #11 showed her mouth which contained no upper teeth and several bottom teeth. An annual minimum data set assessment (MDS) dated 8/21/2012 indicated Resident # 11 required extensive assist of one staff member for personal hygiene and had obvious or likely cavities or broken or missing natural teeth. 2. Resident #13's record was reviewed on 11/7/2012 at 2:44 P.M. Resident #13 was admitted on			

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	8/23/10 and had current diagnoses which included but were not limited to Alzheimer's disease, senile dementia, and hypertension. His primary language was Spanish. He could speak and understand some English but his wife was his main translator. Resident #13 currently received medicaid services. An annual minimum data set assessment (MDS) dated August 21, 2012 indicated he had broken or loosely fitting full or partial dentures and obvious or likely cavity or broken natural teeth were present. 3. Resident #27's record was reviewed on 11/8/2012 at 9:05 A.M. Resident #27 was admitted to the facility on 7/2/2012 and had current diagnoses which included but were not limited to diabetes type II, dementia, depression, pain, and Lou Gehrig's disease. Resident #27 currently received medicaid services. Resident #27 had a current physician's order originally dated 7/2/10 and on the current November 2012 recapitulation orders which indicated he may be seen by a dentist. An annual minimum data set			

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	assessment (MDS) dated August 7, 2012, indicated Resident #27 did not have teeth. During an interview on 11/8/2012 at 3:00 P.M., The Social Service Director stated, "We don't offer routine dental care. We use to but we were handing out $60.00 a month for them to come in and say they don't have teeth. Unless there is complaints of pain or something unusual then we will send them to a dentist. Nursing will notify me or I will notify nursing." At this time documentation for dental services was requested for Resident # 27, #11, #13 and no further information was provided at exit. As of 11/13/2012 at 2:26 P.M., documentation of dental/oral/cancer screening exams were not provided for Resident #11, #13, and #27. 3.1-24(a)(1)			

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review the facility failed to ensure unattended medication carts were locked for 2 of 3 medication	F0431	All med carts are locked. Additionally there is a reminder attached to each med cart. DON will routinely check carts on daily rounds and address any issues	11/14/2012

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	carts observed and failed to ensure insulins that had expired were removed from the medication room refrigerator for 1 of 1 refrigerator observation for expired medications (Resident # 9, 21 & 24). Findings include: 1. During breakfast on 11/7/12 at 9:15 A.M., the front hall medication cart was observed parked outside the main dining room in the hallway unlocked and unattended. On 11/7/12 at 4:08 P.M. the back hall medication cart was parked near the nurses station unlocked and unattended. During an interview with the Director of Nursing (DON) on 11/13/12 at 8:10 A.M., she indicated she did not know if there was a policy for locking the med carts, we just learned in nursing school the med cart should always be locked when unattended. A current undated facility policy titled, "Storage of Medications" and provided by the DON on 11/13/12 at 9:46 A.M. indicated, "... General Guidelines ... 6. Compartments containing medications are locked when not in use."		as indicated. This has been reviewed with licensed staff - instructions and mandates issued and enforced. Charge nurse is responsible. DON to monitor. All insulin and /or other injectable meds have been reviewed. Expired injectables have been removed and re-ordered. Expired injectables will be removed and re-ordered after 28 days as indicated on date open label. Nurses will check dates daily. DON will check insulins weekly. Additionally, the pharmacy tech will audit opened insulins and injectables monthly. QA will monitor for three months, then for three quarters. Charge nurse is responsible. DON will monitor. Attachment F - Expired Medications	

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	2. The record for Resident #9 was reviewed on 11/8/12 at 3:31 p.m. Diagnoses included but were not limited to diabetes, hypertension, schizophrenia and depression. A current recapitulation for November 2012 for Resident #9 with a physician's order dated 9/26/12 indicated, "...Novolog [insulin]...inject 10 units... in the morning [sign for and] in the evening...Novolog...inject 14 units... daily with lunch...." During an observation for medication storage on 11/7/12 at 3:54 p.m., in the refrigerator in the facility's medication storage room, a vial of Novolog insulin for Resident #9 was observed with an open date of 10/2/12. 3. The record for Resident #21 was reviewed on 11/8/12 at 3:34 p.m. Diagnoses included but were not limited to depression, diabetes, and osteoporosis. A current physician's order for Resident #21 dated 11/7/12 indicated, "...start Lantus [insulin] 22 units qHS [at bedtime]...."			

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	During an observation for medication storage on 11/7/12 at 3:54 p.m., in the refrigerator in the facility's medication storage room, a vial of Lantus for Resident #21 was observed with an open date of 10/2/12. 4. The record for Resident #24 was reviewed on 11/8/12 at 3:26 p.m. Diagnoses included but were not limited to diabetes, hypertension, and mild cognitive impairment. A current recapitulation for November 2012 for Resident #24 with a physician's order dated 2/24/12 indicated, "...Lantus [insulin]...inject 10 units...at bedtime for diabetes...." During an observation for medication storage on 11/7/12 at 3:54 p.m., in the refrigerator in the facility's medication storage room, a vial of Lantus for Resident #24 was observed with an open date of 9/17/12. During an interview on 11/7/12 at 4:05 p.m., LPN #2 indicated insulin should be discarded 30 days after the vial was opened.			

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	A medication storage recommendation sheet was provided by the DoN on 11/13/12 at 7:56 a.m., and the recommendations indicated, "...Based on American Diabetes Association guidelines, all unopened insulins are recommended to be stored in the refrigerator. All vials should be dated when opened and discarded 28 days [underlined] after opening...." 3.1-25(m) 3.1-25(o)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview the facility failed to ensure	F0441	Infection control - dressing change inservice done for all	11/14/2012

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	proper handwashing and proper infection control technique during a dressing change for 1 of 2 dressing changes observed (Resident #11). Findings include: Resident #11's record was reviewed on 11/07/2012 at 1:06 P.M. Resident #11 was admitted to the facility on 8/23/2010 and readmitted on 4/7/2012. She had current diagnoses which included but were not limited to diabetes type II, multiple sclerosis, hypertension, asthma, osteoarthritis, history of MRSA (Methicillin Resistant Staph Aureus, congestive heart failure, and a stage 3 pressure area to her right ischium. During an observation on 11/7/2012 at 11:00 A.M., Licensed Practical Nurse (LPN) #4 was observed changing Resident #11's dressing to her pressure area. LPN #4 opened the Treatment Administration Record (TAR) and read the treatment order. He then entered Resident #11's room. He did not wash his hands. He put gloves on and with the help of a Certified Nursing Assistant (CNA)positioned Resident #11 on her left side. Resident #11 was observed to have a stage 3 pressure area on her right buttock area uncovered and a covered area on her left buttock area. LPN #4		licensed staff. One on one inservice done with LPN #4 to ensure proper training and ability to perform procedure. LPN #4 will be under observation for following and preforming procedure with re-training as needed. All nurses will be monitored at least one time weekly for proper procedure. DON will monitor performance during periodic dressing changes. Charge nurses are responsible. DON will monitor by observation. QA will monitor for three months and quarterly thereafter. Attachment G - Infection Control	

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	removed the dressing from the left buttock wound. He put the old dressing on Resident #11's bed. The box of 4 X 4 s were sat on the resident's bed. He did not change his gloves at this time. He then cleaned the right buttock wound with normal saline, packed the wound with Alginate, applied Santyl to the peri wound, and then covered the wound with 4 X 4 gauze. At this time he took his gloved hands and patted his scrub top and bottom and stated, "I know I have scissors." He then reached into his scrub pocket and pulled out bandage scissors. He did not clean the scissors or change gloves. He then cut the tape and covered the wound dressing. At this time he took his gloves off and without washing his hands put new gloves on. He then cleaned the left buttock wound with normal saline, applied Santyl and covered with 4 X 4's. With the same contaminated scissors he cut tape and covered the wound. He picked up the trash from the resident's bed put it in a plastic bag. He then repositioned the resident and took the gloves off. At this time he put the contaminated scissors back into his scrub pocket without cleaning them. Without washing his hands he picked up the supplies, left the room, and returned the supplies back to the treatment cart.			

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	A facility policy titled "Infection Control Dressing Change" provided by the Director of Nursing on 11/8/2012 at 4:09 P.M. indicated, "identify self to res, explain procedure, wash hands, position supplies on clean field, open dressings, other treatment supplies, prep for use, provide privacy for resident, don gloves and remove soiled dressing, discard in trash receptacle (lined), wash hands, don clean gloves, follow directions of treatment for cleansing area, remove gloves, wash hands, don clean gloves and continue with the application of the clean dressing, when treatment done, reposition resident for comfort, leave call light in reach, open privacy curtain, remove gloves and wash hands, remove treatment supplies to appropriate area on treatment cart, don gloves and clean scissors and return to appropriate location, remove soiled dressings from room in closed trash can liner and dispose in biohazard container, remove gloves, wash hands, document treatment and pertinent information." 3.1-18(a)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR HEALTHCARE	2926 N CAPITOL AVE INDIANAPOLIS, IN 46208

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F0458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on record review and observation, the facility failed to ensure resident bedrooms measured at least 80 square feet per resident for 6 of 28 rooms. The deficient practice had the potential to affect 12 of 12 residents who resided in these rooms. (Room # 19, 20, 22, 25, 26 and 27). Findings include: A review of the facility's "Bed Inventory Sheet" dated 11/5/12 , indicated rooms numbered 19, 20, 22, 25, 26 and 27 were listed as certified Medicaid (NF) Rooms. During the entrance tour on 11/5/12 at 8:30 A.M., it was observed rooms 19, 20, 22, 25, 26 and 27 lacked 80 square feet (sq. ft.) per resident. All identified rooms contained two beds. Review of facility measurements for resident rooms numbers 19, 20, 22, 25, 26 and 27, indicated the bedrooms lacked 80 sq. ft. per resident. All identified rooms contained two beds.	F0458	Facility request a waiver for bedroom size on rooms # 19,20,22,25,26 and 27.	11/14/2012

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	Room number, number of beds, total square feet per room and square feet per bed were as follows: *19 - 2, 153.38 sq. ft., 76.69 sq. ft. *20 - 2, 142.46 sq. ft., 71.23 sq. ft. *22 - 2, 142.09 sq. ft., 71.05 sq. ft. *25 - 2, 157.01 sq. ft., 78.51 sq. ft. *26 - 2, 145.93 sq. ft., 72.97 sq. ft. *27 - 2, 154.65 sq. ft., 77.33 sq. ft. 3.1-19(f)(1) 3.1-19(f)(2) 3.1-19(f)(3) 3.1-19(f)(4) 3.1-19(f)(8)			

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F0465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to ensure two facility unisex resident restrooms were sanitary and failed to ensure a wall in a resident's room and a wall in a unisex facility restroom were in good repair. Findings include: An environmental tour was conducted on 11/08/12 at 1:27 p.m. with the facility's Maintenance Supervisor. 1. In resident room #27 a hole was observed through the dry wall behind the door at the level of the door handle. The Maintenance Supervisor indicated he placed a piece of wood behind the door to keep the door handle from going through the wall, but "they moved the wood." The Maintenance Supervisor indicated he does not keep a record of repairs that need to be completed, nor a record of repairs that have been completed. 2. A unisex resident restroom located in the back hall labeled, "Women/Men Restroom" had a wet floor	F0465	All residents have the potential to be affected. The hole in the drywall behind the door in room #27 was repaired and repainted. The drywall in the unisex restroom located in the back hall was replaced and the code base was reinstalled. A leaking plumbing joint was repaired to eliminate the pooling of water under the sink fixture. Housekeeping staff has been counseled on consistent cleanliness of all restrooms. To ensure quality control, a log has been placed on the back of each restrooms' door to be signed by the housekeeper every one half hour that the restroom was cleaned and stocked. QA will review and monitor logs for three months and then quarterly thereafter. Housekeeping is responsible.	11/14/2012

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	underneath the sink. The baseboard stripping along the wall underneath the sink was missing with deterioration and holes in the drywall. Multiple brown smears were observed on the seat of the commode and on the edges of the sink basin. Two metal coat hangers were on the floor in the restroom. A strong foul odor was noted. The Maintenance Supervisor indicated housekeeping was responsible for cleaning the restroom which was used by independent residents. 3. The shower room located in the middle hall had urine in the toilet and the toilet paper roll was empty. The Maintenance Supervisor indicated housekeeping was responsible for cleaning the restroom which was used by independent residents. During an interview on 11/13/12 at 1:19 p.m., Housekeeper #1 indicated there were three facility restrooms used by multiple independent residents. Housekeeper #1 indicated the restrooms were checked and cleaned first thing every morning and then as needed throughout the day. Housekeeper #1 indicated "By the time you get down the hall, the first restroom cleaned is dirty again." Housekeeper #1 indicated there was			

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	an evening shift housekeeper from 5:00 p.m. until 8:00 p.m. Housekeeper #1 indicated there was not a night shift housekeeper, and the restroom in the back hallway, "Is always a mess in the morning." 3.1-19(f)			