

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: November 15, 16, 17, 18, 21, 2011</p> <p>Facility Number: 000005 Provider Number: 155005 AIM Number: 100270840</p> <p>Survey Team: Tammy Alley, RN-TC Donna M. Smith, RN Toni Maley, BSW Linn Mackey, RN (November 16, 17, 18, 2011)</p> <p>Census Bed Type: SNF: 28 SNF/NF: 121 Total: 149</p> <p>Census Payor Type: Medicare: 15 Medicaid: 100 Other: 34 Total: 149</p> <p>Sample: 24 Supplemental Sample: 15</p> <p>These deficiencies also reflect state</p>	F0000	<p>December 11, 2011 Long Term Care Division, 4 th Floor 2 North Meridian Street Indianapolis, IN 46204 RE: ManorCare Health Services of Anderson 1345 N. Madison Ave. Anderson, IN 46011 Dear Kim Rhoades: Please note our Plan of Correction and allegation of complice for the Recertification and State Licensure Survey completed on November 21, 2011. We respectfully request a desk review. Should you have any other questions or need additional information, please contact me at the above address or phone number. You may also contact me via email at 421admin@hcr-manorcare.com. Sincerely, Nicole Fields, HFA Administrator</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0176 SS=D	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 29, 2011 by Bev Faulkner, RN</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on record review, observation and interview, the facility failed to ensure residents who were observed self-administering respiratory medications and/or treatments were assessed and deemed appropriate to self-administer medications for 3 of 3 residents observed in a sample of 24. (Resident # 100, #99, and # 85)</p> <p>Findings include:</p> <p>1. The record for Resident # 100 was reviewed on 11/18/11 at 11:45 a.m.</p> <p>Current diagnoses included, but were not</p>	F0176	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 100 and #85 will be assessed for self administration of medication per the facility guidelines. Resident # 99 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 actions will be taken; A chart audit was completed to identify residents with orders for nebulizer therapy and hand held inhalation. The identified residents will be assessed for self administration</p>	12/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>limited to, subarachnoid bleed and Chronic Obstructive Pulmonary Disease.</p> <p>The current physician orders for November 2011 indicated an order for Duoneb every 6 hours per nebulizer with times listed as 12 a.m., 6 a.m., 12 p.m., and 6 p.m.</p> <p>The record lacked an assessment to self-administer medications.</p> <p>On 11/15/11 at 11:55 a.m., Resident #100 was observed in his room in bed. His nebulizer treatment was running and he had the mask in his hand then placed the mask back on his face. There was not nurse present in the room or in the hallway near the resident's room.</p> <p>2. The record for Resident # 85 was reviewed on 11/16/11 at 9:10 a.m.</p> <p>Current diagnoses included, but were not limited to, pneumonia and Cerebral Palsy.</p> <p>Physician orders for November 2011 indicated an order for Duoneb three times daily per nebulizer.</p> <p>The record lacked an assessment to self-administer medications.</p> <p>On 11/18/11 at 8:25 a.m., Resident #85</p>		<p>of medication per the facility guidelines. Licensed Nurses will be educated on the guidelines for Medication Administration, including the guidelines for self administration of medication.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</p> <p>Residents identified as meeting the criteria to self administer medications will have an assessment completed and documented education per the facility guidelines. The Director of Care Delivery or Designee will conduct random Medication Administration observations on all shifts a minimum of twelve times per week to ensure proper technique and follow up is in place for self administration of medications. 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 into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>was observed in bed. He had his nebulizer tubing connected to his tracheostomy and the treatment was running, and the medication cup was sitting sideways and not in the chamber. No nurse was present in the room or in the hallway. At that time LPN # 11 was summoned to the room. At that time, LPN # 11 indicated she was unsure if a nurse should stay in the room with the resident.</p> <p>On 11/17/11 at 11 a.m., the Director of Nursing indicated no resident in the building had been assessed to self-administer medications.</p> <p>3. On 11/15/11 at 4:00 p.m., medication pass was observed. LPN #22 was observed to prepare Resident #99's oral medications and obtain the Advair Diskus (medication to aid respiratory function). Upon entering the resident's room, LPN #22 handed Resident #99 his Advair Diskus. Resident #99 was observed to turn the diskus to the present dose, place it into his mouth and inhale to complete the administration of this medication. He then handed the Advair diskus back to LPN #22 as he swished water in his mouth and swallowed it.</p> <p>On 11/17/11 at 11:10 a.m., during an interview, the Director of Nursing</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>indicated Resident #99 did not have a self-medication evaluation to self administer his medications.</p> <p>Resident #99's record was reviewed on 11/16/11 at 2:45 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD).</p> <p>The physician's order, dated 9/19/11, was Advair 100-50 diskus inhale 1 puff by mouth 2 times daily with the diagnoses of COPD.</p> <p>4. A policy titled "Step II Assessment of Patient's Ability to Self-Medicate" was provided by the Director of Nursing on 11/17/11 at 10:55 a.m., and deemed as current. The policy indicated: "To evaluate the safety of this practice, a nurse will conduct the following test. If the patient is unable to demonstrate knowledge to assure safe self-administration of medications, self-administration of medications will not be allowed...."</p> <p>3.1-11(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure allegations of abuse were promptly reported to the administrator for 1 of 2 allegation of</p>	F0225	<p>INFORMAL DISPUTE RESOLUTION F225 483.13(c) (1)(ii)-(iii), (c)(2)-(4) Investigate/Report Allegations/Individuals The</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>abuse reviewed in a sample of 24 (Resident #200).</p> <p>Findings include:</p> <p>1.) Resident #200's closed record was reviewed on 11/17/11 at 1:40 p.m.</p> <p>Resident #200's diagnoses included, but were not limited to, major depression and personality mood disorder.</p> <p>Review of a 2/9/11, "Facility Incident Report" indicated Resident #200 reported "a worker slapped her in the face."</p> <p>An undated "Statement of Witness" made by LPN #26 indicated the following "[Resident #200] informed me 2/8/11 about 3 pm that a worker slapped her in the face. I asked if it was a female & she said yes. She said it very nonchalantly & I asked her was she hurt & she said no but she thought it was mean of that girl to slap her."</p> <p>A 2/9/11 "One-On-One Inservice Record" indicated LPN #26 received disciplinary action for not reporting any allegation of abuse immediately to her supervisor.</p> <p>During an interview on 11/17/11 at 1:25 p.m., SSD #27 (Social Service Director) indicated a complete investigation of the</p>		<p><i>facility failed to ensure allegations of abuse were promptly reported to the administrator. The facility respectfully denies and disputes the allegation that it was deficient with regard to F225 and requests that the deficiency identified as F225, be deleted from the public record for reasons set forth herein. The statement of deficiency cites that LPN #26 did not report the allegation to her supervisor immediately after the allegation was made. The Interpretive Guidelines for CFR 483.13 defines immediately as "as soon as possible, but ought not exceed 24 hours after the discovery of the incident, in the absence of a shorter State time frame requirement." (attachment #5) This alleged incident occurred on 2/8/2011 and the investigation was initiated on 2/9/11. The notification and initiation of the investigation did not exceed 24 hours after discovery as defined in the Code of Federal of Regulations within the 24 hours as defined by law. The "Statement of Witness" as well as the one-on one Inservice Record for LPN #26 were both completed on 2/9/11. (attachment #6 and attachment #7) We respectfully request that F225 be deleted from the public record. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>allegation made by Resident #200 was conducted. The allegation was unsubstantiated due to the resident's confusion and change in statements, event, people etc. During the course of the investigation, it was determined LPN #26 did not report the allegation to her supervisor immediately after the allegation was made. The supervisor would then report to the administrator. Disciplinary action was taken in order to re-educate LPN #26 regarding mandatory prompt reporting of all allegations of abuse.</p> <p>3.1-28(c)</p>		<p>200 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 actions will be taken; All residents have the potential to be affected by this deficient practice. LPN #26 was reeducated on 2/9/11. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: Facility staff will be inserviced on the facility abuse guidelines inclusive of timely notification of abuse. The Social Services Director or designee will audit a minimum of 5 staff members 3 times per week to validate knowledge retention related to timely reporting of abuse. 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 into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**Will facility staff inservicing include the regulatory requirement to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0226 SS=D	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure staff implemented the facility abuse prevention policy for 1 of 2 allegation of abuse reviewed in a sample of 24 (Resident #200).</p> <p>Findings include:</p> <p>1.) Resident #200's closed record was reviewed on 11/17/11 at 1:40 p.m.</p> <p>Resident #200's diagnoses included, but were not limited to, major depression and</p>	F0226	<p>report ALL allegations of abuse, neglect, and/or misappropriation of property immediately to the facility administrator? Will the Social Services Director or designee audit staff members on all shifts? Facility staff will be inserviced on the facility abuse guidelines inclusive of timely notification of all allegations of abuse, neglect and/or misappropriation of property to the facility administrator. The Social Services Director or designee will interview a minimum of 5 staff members on all shifts 3 times per week to validate knowledge retention related to timely reporting of abuse.</p> <p>INFORMAL DISPUTE RESOLUTION F226 483.13(c) Develop/Implement Abuse/Neglect, Etc Policies <i>The facility failed to ensure allegations of abuse were promptly reported to the administrator. Based on interview and record review, the facility failed to ensure staff implemented the facility abuse prevention policy. Current facility policy titled Abuse, Neglect, Misappropriation of Patient Property Prevention page 11 states "CMS believes "immediately" means as soon as</i></p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>personality mood disorder.</p> <p>Review of a 2/9/11, "Facility Incident Report" indicated Resident #200 reported "a worker slapped her in the face."</p> <p>An undated "Statement of Witness" made by LPN #26 indicated the following "[Resident #200] informed me 2/8/11 about 3 pm that a worker slapped her in the face. I asked if it was a female & she said yes. She said it very nonchalantly & I asked her was she hurt & she said no but she thought it was mean of that girl to slap her."</p> <p>A 2/9/11 "One-On-One Inservice Record" indicated LPN #26 received disciplinary action for not reporting any allegation of abuse immediately to her supervisor.</p> <p>During an interview on 11/17/11 at 1:25 p.m., SSD #27 (Social Service Director) indicated a complete investigation of the allegation made by Resident #200 was conducted. The allegation was unsubstantiated due to the resident's confusion and change in statements, event, people etc. During the course of the investigation, it was determined LPN #26 did not report the allegation to her supervisor immediately after the allegation was made. The supervisor would then report to the administrator.</p>		<p>possible, but ought not exceed 24 hours after the discovery of the incident, in the absence of a shorter time frame requirement. (Attachment #8) This alleged incident occurred on 2/8/2011 and the investigation was initiated on 2/9/11. The notification and initiation of the investigation did not exceed 24 hours after discovery as defined in the Code of Federal of Regulations within the 24 hours as defined by law. We respectfully request that F226 be deleted from the public record.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 200 no longer resides at the facilityHow other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; All residents have the potential to be affected by this deficient practice. LPN #26 was reeducated on 2/9/11.What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: Facility staff will be inserviced on the facility abuse guidelines inclusive of timely notification of abuse.The Social Services Director or designee will audit a minimum of 5 staff members 3 times per week to validate knowledge</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Disciplinary action was taken in order to re-educate LPN #26 regarding mandatory prompt reporting of all allegations of abuse.</p> <p>Review of a current, 4/21/06, facility policy titled "Abuse, Neglect, Misappropriation of Patient Property Prevention, which was provided by the Administrator on 11/15/11 at 1:10 p.m., indicated the following:</p> <p>"The facility must ensure that all allegations violations are reported immediately to the administrator..."</p> <p>3.1-28(a)</p>		<p>retention related to timely reporting of abuse. 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 into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**Will facility staff inservicing include the regulatory requirement to report ALL allegations of abuse, neglect, and/or misappropriation of property immediately to the facility administrator? Will the Social Services Director or designee audit staff members on all shifts? Facility staff will be inserviced on the facility abuse guidelines inclusive of timely notification of all allegations of abuse, neglect and/or misappropriation of property to the facility administrator. The Social Services Director or designee will interview a minimum of 5 staff members on all shifts 3 times per week to validate knowledge retention related to timely reporting of abuse.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011			
(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			
F0244 SS=E	<p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on observation, interview and record review, the facility failed to resolve Resident Council grievances regarding passing fresh water and timely meal service for 7 of 9 residents interviewed in a confidential group setting. The nine residents attending the group meeting were Residents #35, #76, #145, #33, #64, #60, #142, #19 and #12.</p> <p>Findings include:</p> <p>1.) An 11/16/11, 2:00 p.m., group interview was conducted with residents who were identified as interviewable by the Activity Director at this time. The following nine residents attended the confidential group meeting, Residents #35, #76, #145, #33, #64, #60, #142, #19 and #12. The following concerns regarding the failure to resolve Resident Council concerns were expressed:</p> <p>a.) Resident Council had reported repeated concerns regarding late meal service and the failure to pass ice water each shift. These problem remain uncorrected.</p>	F0244	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Grievances related to meals and ice water passes for resident #'s 35, 76, 145, 33, 64, 60, 142, 19 and 12 were satisfactorily resolved. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; All residents have the potential to be affected by this deficient practice. Department Heads will be educated regarding the process for resolving group greivances reported during Resident Council meetings. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: The Activity Director or designee will complete audits a minimum of 3 days per week for satisfactory resolution of issues identified during Resident Council Meeting. 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</p>	12/21/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>b.) 7 of 8 responding residents indicated meals were served late three times a week or more.</p> <p>c.) 4 of 8 responding residents indicated ice water was not passed each shift three times a week or more.</p> <p>2.) Review of Resident Council Minutes from April 2011 to current included, but were not limited to, the following concerns regarding the passing of ice water and timely meal service:</p> <p>a.) 4/25/11-"meal time is getting later & later each time" and "they are not getting their water."</p> <p>b.) 5/23/11-"They would also like to see meal times actually being served as scheduled" and "They would also like to have fresh cold water each morning."</p> <p>c.) 6/27/11-"would like...fresh cold water."</p> <p>d.) 8/29/11-"Fresh water is not being passed."</p> <p>e.) 9/26/11-"Meals are running late" and "Water is not being passed to rooms each shift."</p>		<p>into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**Will the audits completed by the Activity Director or designee include resident interviews? If so, how many audits/interviews will be completed each week and for how long? If less than six months, what is the specific criteria to discontinue the audits/interviews.The Activity Director or designee will complete a minimum of five audits/resident interviews per week for satisfactory resolution of issues identified during Resident Council Meeting. Audit/Interview findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>f.) 10/31/11-"...employees pass water but not on a regular basis"</p> <p>Review of a facility provided form titled "Meal Service Times", which was provided by the Administrator on 11/15/11 at 2:00 p.m., indicated the following: Family Tree dining room breakfast 7:45 a.m.</p> <p>During an 11/17/11 breakfast meal observation, breakfast service did not begin in the Family Tree dining room until 8:34 a.m., which was 49 minutes after the scheduled meal time.</p> <p>During an 11/18/11 breakfast meal observation, breakfast service did not begin in the Family Tree dining room until 8:25 a.m., which was 40 minutes after the scheduled meal time.</p> <p>3.1-3(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

F0252 SS=C	<p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation, record review, and interview, the facility failed to ensure the facility was clean and in good repair related to soiled carpets, torn and peeling wallpaper and paint, dirty walls, floors, vents, cabinets, chairs, baseboards, closets, and broken and cracked floor tiles. This deficit practice had the potential to affect 149 of 149 residents who reside in the building.</p> <p>Findings include:</p> <p>1. During the environmental tour on 11/16/11 at 9 a.m., with the Maintenance Director and the Environmental Services Director the following was observed.</p> <p>Front Entrance: The carpet at the main entrance doors was worn and faded at the double door entrance. There was a 3 foot by 3 foot area of staining under the water fountain and a small saucer size area under the alcohol hand sanitizer dispenser. The carpet was frayed at the entrance of the men and women's restrooms doors. There were also 3 areas of torn wallpaper in the entry way to the skilled hall toward the</p>	F0252	<p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: A purchase order has been completed and approved at the corporate level for the carpet to be replaced at the main entrance doors. The Intermediate Unit baseboards have been cleaned or replaced as appropriate. The Intermediate Unit nursing station wood panel has been cleaned the baseboard has been replaced. The exit door by the nurses station has been cleaned and the cobwebs in the window and around the baseboard have been removed. The baseboard under the heating unit in room 140 has been installed. The floor in room 155B has been cleaned. The privacy curtain was laundered and rehung. The tiles at the bathroom door have been repaired. The bathroom door has been repainted. The activity room wall, trash can, refrigerator, freezer and sink cabinet was cleaned of the splatters and spillage. The soilage on the top and bottom cabinet doors has been cleaned. The sheers in room 160 were replaced. The closet door was painted. The</p>	12/21/2011
---------------	---	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>therapy rooms.</p> <p>Intermediate Unit: The baseboards throughout the intermediate unit were splattered with brown and white substances.</p> <p>The intermediate nurses station's wood panel had dust and debris in the groves at the base and there was torn base boards on the right side of the nurses's station.</p> <p>The exit door by the nurse's station windows was soiled with a milky film, there were cob webs in the windows and around the baseboard by the door.</p> <p>Room 140: The baseboard under heating unit was missing</p> <p>Room 155: The floor beside and around Bed B was soiled with splatters and debris. The privacy curtain had areas of brown splatters around Bed B. The tiles at the bathroom door were broken and the bathroom door facing had chipped paint approximately 12 inches up from the floor.</p> <p>Activity room: The right side wall has scattered splatters of brown substances. The trash can by the</p>		<p>floor around the baseboards was cleaned. The wallpaper by the wall by bed A was repaired. The floor around the baseboards in room 146 was cleaned. The chipped paint on the register was repainted. The closet floor track and feeding pump was cleaned. The floor around the baseboard in room 166 was cleaned. The closet floor track was cleaned. The area above the air conditioning unit was repainted and nightstand drawer was repaired. The outlet cover was replaced and the feeding pump, night stand, television were cleaned. The baseboard and wallpaper outside of the shower room was repaired or replaced as appropriate. The door frame was repainted. A purchase order has been completed and approved at the corporate level for wall vinyl in the hallway to be repaired or replaced as appropriate. The ceiling vent outside of room 175 was cleaned and the ceiling tiles have been replaced. The baseboards in the main dining room have been cleaned or replaced as appropriate. A purchase order has been completed and approved at the corporate level for wall vinyl in the main dining room to be repaired or replaced as appropriate. The chairs in the main dining room have been cleaned. The floor and baseboards in the occupational therapy room have been cleaned and waxed as</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>refrigerator was splattered with brown substances around the bottom and the foot pedal. The sink cabinet had dark splatters and soilage on the cabinet doors top and bottom. The refrigerator had a spilled red drink down the inside door and the freezer had a dark brown circular area of spillage and the door had spillage.</p> <p>Room 160: The sheers were frayed at the bottom with long fabric strings hanging. The closet door had chipped paint half way up the door, the floor was soiled around the baseboards with a build-up of gray dirt and debris. The wall paper was torn on the wall by Bed A and there was debris under the bed.</p> <p>Room 146: The floor was soiled with dark gray substance around the baseboards. The register on the left side of the room had chipped paint approximately 5 feet across. The closet floor track had a build up of dust and debris. The feeding pump had splatters of a tan substance on all 4 legs.</p> <p>Room 166: The floor was soiled with a dark gray substance around the baseboards, the closet floor track was filled with dust and debris. The air conditioning unit had cracked and chipped paint above the unit.</p>		<p>appropriate. The floor in the physical therapy room has been cleaned and waxed as appropriate. The dust in the heating unit has been removed and the exit door to the courtyard has been cleaned of dirt and dust by the door. A purchase order has been completed and approved at the corporate level for the carpet to be replaced on the Medicare unit. The stained ceiling tiles have been replaced. The scuff marks on the following doors have been cleaned or repainted: Medicare shower room A and B, medicare soiled utility room, mechanical room on the medicare hall, the environmental storage room on the medicare hall, the men's and women's public restroom doors, and the Director of Care delivery doors. A purchase order has been completed and approved at the corporate level for wall vinyl and floor tile on the Family Tree unit including repairing or replacing floor tile in rooms 409 and 418 and repairing or replacing wall vinyl in 400 hallway, rooms 408 and 410. The 12 inch crack in the lower bathroom wall of room 418 has been repaired. The door to room 421 has been repainted. The floor in the Arcadia activity room has been cleaned and waxed as appropriate. The cobwebs in each end of the window were removed in room 314. The loose screen was repaired A purchase</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>The second drawer of the night stand by the Bed B was hanging. The wall between the bed had an outlet that had no cover. The feeding pump by Bed A was splattered with a tan substance on all four bases and the night stand and television by Bed A was also splattered with a tan substance.</p> <p>Shower room: The baseboard and wallpaper outside the shower room door was pulling away from the wall. The door frame to the bathroom area had chipped paint approximately 8 inches up the frame.</p> <p>Hallway: There were numerous areas of torn wall paper in the 170's hallway. The ceiling vent outside Room 175 had an accumulation of dust and had dark water spots on the surrounding tiles.</p> <p>Main dining room: The baseboards throughout the dining room had splatters and spillage. The wall paper throughout had area of torn areas. Eleven (11) of 12 of the dining room chairs had splatters of food and drink substances on the seats, seat backs, arms and legs.</p> <p>Occupational Therapy room: There was debris and cob webs around the</p>		<p>order has been completed and approved at the corporate level for floor tile on the Family Tree unit including repairing or replacing tile in the Arcadia dining room. The lower 3 drawer cabinet was cleaned. The floor in the Arcadia dining room has been cleaned and waxed as appropriate. A purchase order has been completed and approved at the corporate level for wall vinyl and floor tile on the Family Tree unit including repairing or replacing wall vinyl in Arcadia hallway, 200 hall including between rooms 200 and 202, near room 205, and the bathroom in 209. A purchase order has been completed and approved at the corporate level for floor tile on the Family Tree unit including repairing or replacing floor tile in the Family Tree lounge, at the entry of the 200 hall, between rooms 203 and 205, between rooms 203 and 200, and the bathroom floor in room 520. The wall between the floor and cove base in room 208 was cleaned. The floor in the activity room has been cleaned and waxed as appropriate. The tiles with the rust spots have been replaced. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: An environmental audit was completed in the resident care areas and the appropriate</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>baseboards and the floor tiles were dull and discolored.</p> <p>Physical Therapy room: Floors tiles were dull and discolored. The heating unit vent had a build up of dust. The exit door to the courtyard had a build up of dirt and dust by the door.</p> <p>Medicare unit: The carpet between Rooms 110 -120 had multiple discolored areas ranging in size from a quarter to larger than a platter. Seven ceiling tiles outside the nursing station had brown water spots.</p> <p>Throughout the front part of the building there were doors with black scuff marks 6-12 inches up the door from the floor including the following doors: Medicare shower room A and B, medicare soiled utility room, the mechanical room on the medicare hall, the environmental storage room on the medicare unit, the public men's and women's bathroom doors at the front entrance, and the Director of Care's office door.</p> <p>On 11/18/11 at 10:10 a.m., the Environmental Service Director provided a house-wide cleaning schedule. Review of the cleaning schedule indicated the deep cleaning schedule had the ancillary areas scheduled at least monthly. She</p>		<p>corrective action initiated. Facility staff will be educated on the importance of maintaining a clean, comfortable and homelike environment. Environmental Service staff have been educated on the importance of daily disinfecting and cleaning of all surfaces. Floors and baseboards will be put on a routine cleaning and resurfacing schedule. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: The Environmental Services Director, Maintenance Director or designee will randomly audit the resident rooms and related patient care areas cleanliness a minimum of 3 days per week. How the corrective action (s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance will be put into place; Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**For each purchase order completed and approved by corporate, please indicate the expected date the repair or replacement will begin, and the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	indicated resident rooms were deep cleaned monthly and the staff informed her when each room was completed.		expected/approximate date of completion. FYI: The survey team may review any approved contractor quotes and/or approved work orders for work that is not completed at the time of the revisit. A purchase order has been completed and approved at the corporate level for the carpet to be replaced at the main entrance doors. This work was initiated on 12/21/2011. The expected completion date for this work is 12/23/2011. A purchase order has been completed and approved at the corporate level for wall vinyl in the hallway to be repaired or replaced as appropriate. This work will start on or about 1/20/2012 and will be completed no later than 2/20/2012. Approved quotes and/or work orders will be made available to the survey team in the event the work is not completed at the time of the revisit. A purchase order has been completed and approved at the corporate level for wall vinyl in the main dining room to be repaired or replaced as appropriate. This work will start on or about 1/20/2012 and will be completed no later than 2/20/2012. Approved quotes and/or work orders will be made available to the survey team in the event the work is not completed at the time of the revisit. A purchase order has been completed and approved at the corporate level for the carpet		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
			to be replaced on the Medicare unit. This work will start on or about 2/13/2012 and will be completed no later than 3/8/2012. Approved quotes and/or work orders will be made available to the survey team in the event the work is not completed at the time of the revisit. A purchase order has been completed and approved at the corporate level for wall vinyl on the Family Tree unit including repairing or replacing wall vinyl in 400 hallway, rooms 408 and 410. A purchase order has been completed and approved at the corporate level for wall vinyl in the main dining room to be repaired or replaced as appropriate. This work will start on or about 1/20/2012 and will be completed no later than 2/20/2012. Approved quotes and/or work orders will be made available to the survey team in the event the work is not completed at the time of the revisit. A purchase order has been completed and approved at the corporate level for floor tile on the Family Tree unit rooms 409 and 418. This work was initiated on 12/21/2011. The expected completion date for this work is 12/23/2011. A purchase order has been completed and approved at the corporate level for floor tile on the Family Tree unit including repairing or replacing tile in the Arcadia dining room. This work will start on or about 2/13/2012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	2. On 11/16/11 from 12:35 p.m. to 1:50		and will be completed no later than 3/8/2012. Approved quotes and/or work orders will be made available to the survey team in the event the work is not completed at the time of the revisit. A purchase order has been completed and approved at the corporate level for wall vinyl on the Family Tree unit including repairing or replacing wall vinyl in Arcadia hallway, 200 hall including between rooms 200 and 202, near room 205, and the bathroom in 209. This work will start on or about 1/20/2012 and will be completed no later than 2/20/2012. Approved quotes and/or work orders will be made available to the survey team in the event the work is not completed at the time of the revisit. A purchase order has been completed and approved at the corporate level for floor tile on the Family Tree unit including repairing or replacing floor tile in the Family Tree lounge, at the entry of the 200 hall, between rooms 203 and 205, between rooms 203 and 200, and the bathroom floor in room 520. This work will start on or about 2/13/2012 and will be completed no later than 3/8/2012. Approved quotes and/or work orders will be made available to the survey team in the event the work is not completed at the time of the revisit.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>p.m., the environmental tour was completed with the Maintenance Director and the Director of EVS (Environmental Services). The following was observed:</p> <p>Room 409: A pencil thin gap was observed between the room and entry to the bathroom. A brown accumulated substance was observed in this gap.</p> <p>Room 418: The 12 inch floor tiles upon entering the bathroom from the room were observed with an irregular edge leaving a gap between the floor tiles from the room to the bathroom. A brown accumulated substance was observed in the irregular gap. An irregular 12 inch crack was observed on one of the lower bathroom walls.</p> <p>In the 400 hallway at the exit doors, a two inch area of the wallpaper seam was peeling away from the wall.</p> <p>The wallpaper between Room 408 and room 410 was observed with small torn areas.</p> <p>Room 421: The lower 1/2 of the door was observed scuffed up, marred, and scratched up.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>The Arcadia Activity Room: Spilled dried brown spots were observed. The floor was observed dull and discolored.</p> <p>Room 314: Cobwebs were observed in each end of the room's window and along the bottom screens with 1 screen loose and out of the track. At this same time during an interview, the Director of EVS indicated the windows were washed 2 times a year, and she needed to schedule the window cleaning soon as she had not scheduled the window washing at this time.</p> <p>Arcadia dining room: Upon entering the room, the gap between the tiles at the entrance and around the corners of the door threshold were observed with an accumulation of a brown substance. To the right in the cabinet area, the lower 3 drawer cabinet was observed with the orange/brown caked on substance on the top of the grooves of each drawer. The floor was observed discolored and dull. At this same time during an interview, the Director of EVS indicated the dining room area was cleaned several times a day.</p> <p>In the Arcadia hallway: The lower wall under the handrails were</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>observed with black scuffed/marred areas and scattered areas of torn wallpaper and loose wallpaper seams.</p> <p>The Family Tree lounge: Under the table at the pole, at least nine 12 inch floor tiles were observed with pencil thin gaps between the tiles. In these gaps, a black substance was observed with the black substance extending onto the floor tiles in a smear-like pattern. Smaller areas that ranged from two to six 12 inch sized floor tiles, with this same black substance and smearing were observed in different areas of this same room under the phone table, computer table, and puzzle table. At the entry doorway from the 200 hall, 2 irregular, diamond shaped corners of the 12 inch floor tiles were missing.</p> <p>At the entry to the 200 hallway around the shower room and water fountain, eight 12 inch floor tiles in a zig zag pattern was observed with pencil thin gaps with dark brown to black substance observed in the gaps.</p> <p>Between Room 200 and Room 202, the wallpaper was observed coming off around the handrail.</p> <p>Between Rooms 203 to 205, fifteen of the 12 inch floor tiles were observed with a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>dark brown to black substance.</p> <p>By Room 205, a wallpaper seam was coming apart below the handrail.</p> <p>Between Rooms 203 to 200, six 12 inch floor tiles were observed with the dark brown to black substance in the pencil thin gaps.</p> <p>Down the 200 hallway, various scattered areas of torn and scuffed/marred wall paper was observed.</p> <p>Room 209's bathroom: The wallpaper was peeling away from the lower wall on each side of the toilet.</p> <p>Room 208: As one was looking in the room, the wall to the left was observed with a brown accumulated substance along the junction of the floor and wall cove base. At this same time during an interview, the Director of EVS indicated the floor scrubber was not always good about cleaning along the wall.</p> <p>Room 520: Two of the 12 inch floor tiles at the bathroom and room entrance had the corners missing with a black-like glue substance on them.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Activity room: Loose gray and brown dirt/dust was noted around the room with accumulation in the corners of the room and around the heaters below the outside windows. The floor was observed discolored and dull. Also, on the floor next to the microwave table, an orange rust-like area was observed. At this same time during an interview, the Director of EVS and Maintenance Supervisor indicated a freezer used to be located in that same area and was removed. At this same time, the Director of EVS indicated activity personnel were responsible for cleaning the activity room, and the Activity Assistant #24, who was present in the room, indicated the room was cleaned about 3 times a week.</p> <p>Lounge across from the activity room: The carpeted area was observed with black stained-like areas throughout the carpeting, especially in the traffic areas.</p> <p>3.1-19(f)(5)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure Accuchecks (finger stick blood glucose testing) were completed as ordered by the physician for 2 of 5 residents reviewed for Accuchecks (Resident # 142 and # 100). The facility also failed to ensure physician orders were followed for removal of a transdermal patch for 1 of 1 resident reviewed for patches in a sample of 24. (Resident # 85)</p> <p>Findings include:</p> <p>1. The record for Resident # 142 was reviewed on 10/18/11 at 2 p.m.</p> <p>Current diagnoses included, but were not limited to, Diabetes Mellitus.</p> <p>Current physician orders for November 2011 indicated an order for Accuchecks and sliding scale insulin 4 times daily. The original date of the order was 10/3/11.</p> <p>The October Medication Administration Record (MAR) for 2011 lacked</p>	F0282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #142 no longer resides at the facility</p> <p>The clinical record for resident #100 was reviewed and the resident is receiving insulin and accuchecks per the physician's order.</p> <p>The transdermal patch for resident #85 was removed at the time the discrepancy was identified. The resident was assessed for negative outcomes with none noted. Notification of the incident was completed to the physician and family.</p> <p>How other residents having the</p>	12/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
	<p>Accucheck results or sliding scale insulin on 10/23/11 at 11 a.m., 10/20/11 at 11 a.m., 10/25/11 at 4 p.m., and 8 p.m.</p> <p>On 11/18/11 at 1:30 p.m., additional information regarding the above Accuchecks was requested from the Director of Nursing.</p> <p>On 11/21/11 at 9:40 a.m., during interview, the Director of Nursing indicated she had no additional information to provide.</p> <p>2. The record for Resident # 100 was reviewed on 11/18/11 at 11:45 a.m.</p> <p>Current diagnoses included, but were not limited to, Diabetes Mellitus.</p> <p>Physician orders for November 2011 indicated an order for Accuchecks and sliding scale insulin to be completed 4 times daily.</p> <p>The MAR for November 2011 lacked Accucheck and sliding scale insulin on 11/5/11 at 7 a.m.; 11/7/11 at 11 a.m., and 8 p.m., and 11/16/11 at 11 a.m.</p> <p>On 11/18/11 at 1:30 p.m., additional information regarding the above Accuchecks was requested from the Director of Nursing.</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart audit was completed to identify other residents receiving accuchecks to ensure completion as ordered by the physician.</p> <p>Licensed nursing staff will be educated on the guidelines for obtaining accuchecks including documentation of results.</p> <p>A chart audit was completed to identify other residents receiving transdermal patches to ensure placement as ordered by the physician.</p> <p>Licensed nursing staff will be educated on the guidelines for medication administration including placement and removal of transdermal patches.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>On 11/21/11 at 9:40 a.m., during interview, the Director of Nursing indicated she had no additional information to provide.</p> <p>3. The record for Resident # 85 was reviewed on 11/16/11 at 9:10 a.m.</p> <p>Current physician orders for November 2011 indicated an order for a Transderm-Scop 1.5 milligram patch to be applied every 72 hours for nausea.</p> <p>During a personal care observation of Resident # 85 on 11/15/11 at 3:40 p.m., the resident's gown was removed and a small dime size patch was located on the resident's left upper back and behind his left ear. No time or date was on either patch. At that time, LPN # 11 indicated the resident should not have two patches on. She indicated one is to be removed prior to another being applied.</p> <p>4. A 3/2010 policy titled "Medication Administration: Transdermal Drugs" was provided by the Director of Nursing on 11/16/11 at 1:50 p.m., and deemed as current. The policy indicated: "...Procedure: ...Examine patient's chest, back and shoulders for any residual medication patches. Remove previous patch and wipe away any remaining</p>		<p>practice does not recur:</p> <p>The Director of Care Delivery or designee will conduct random medication administration observations on all shifts a minimum of twelve times per week to monitor that transdermal patches, accuchecks and insulin are completed as ordered by the physician.</p> <p>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 into place:</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0309 SS=D	<p>medication...Label medication administration paper or disk with date, time and initials...."</p> <p>3.1-35(g)(2)</p> <p>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 interview and record review, the facility failed to ensure a resident was assessed and monitored for signs and symptoms of urinary tract infection while awaiting treatment orders for 1 of 5 residents reviewed for urinary tract infections in sample of 24 (Resident #57). In addition, the facility failed to monitor the bowel status for 4 of 20 residents reviewed for bowel monitoring in a sample of 24 (Residents #98, #85, #131 and #141). The facility also failed to provide insulin coverage in accordance with physician's orders for 1 of 5 residents reviewed with diabetes in a sample of 24 (Resident #137).</p>	F0309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A clinical record review was completed for resident #57. Antibiotic therapy was completed and the resident currently has no signs or symptoms of infections. Clinical records have been reviewed for resident #98, 85, 131 and 141. All residents are currently free from signs and symptoms of constipation. A clinical record review was completed for resident #137. Resident will receive insulin and accuchecks as ordered by the physician. How other residents having the potential</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Findings Include:</p> <p>1.) Resident #57's record was reviewed on 11/15/11 at 1:00 p.m.</p> <p>Resident #57's current diagnoses included, but were not limited to, Alzheimer's disease and hypothyroidism.</p> <p>Resident #57 had a 10/27/11, Nurse Practitioner's Note, which indicated U/A C&S (urinary analysis, culture and sensitivity) Now-may in and out catheterize in relation to foul smelling urine.</p> <p>Resident #57 had a 10/27/11, physician's order for a U/A C&S.</p> <p>Resident #57 had a 10/31/11 "Final Report" for a U/A, C&S collected on 10/27/11, which indicated the culture was positive for both Enterococuss Species and Viridans Streptococcus. The form indicated the physician was aware.</p> <p>On 11/4/11, Resident #57 received an order for Amoxicillin 500 mg three times daily for the treatment of a urinary tract infection. This was 4 days after the C&S Final Report.</p> <p>During the four day period following the positive urinary tract infection results and</p>		<p>to be affected by the same deficient practice will be identified and what corrective actions will be taken; A chart audit was completed to identify other residents with a change in condition, included but not limited to signs and symptoms of urinary tract infection, lack of a bowel movement for more than 3 days and omission of medication as ordered by the physician. The Director of Care Delivery or designee will complete a review of the 24 hour report sheet and orders to monitor for acute change in patient condition and completion of pertinent documentation. The Director of Care Delivery or designee will complete a review of all residents bowel movement status to ensure timely follow up if a resident triggers for no bowel movement within 3 days including documentation of assessment. Licensed nursing staff will be educated on the guidelines for medication administration including the administration of insulin and related documentation. Licensed nursing staff will be educated on the guidelines for monitoring for acute change in condition including pertinent documentation, use of critical pathway guidelines, and physician notifications. Licensed nursing staff will be educated on the guidelines for monitoring bowel movement status of residents,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>the beginning of the antibiotic treatment, (10/31/11 to 11/4/11), the clinical record lacked documentation of any monitoring of the resident's overall urinary health during this period. The clinical record lacked monitoring of the color, amount and odor of the urine; the resident's temperature or the resident's pain status.</p> <p>During an 11/17/11, 2:45 p.m., interview, the Director of Nursing indicated, Resident #57's primary physician was notified of the U/A, C&S results and did not respond. Therefore, the Hospice Medical Director ordered the antibiotics on 11/4/11.</p> <p>During an 11/18/11, 1:35 p.m., interview, the Director of Nursing indicated the facility did not have any documentation of monitoring of Resident #57's urinary health while awaiting treatment for a urinary tract infection.</p> <p>2.) Resident # 98's record was reviewed on 11/15/11 at 3:45 p.m.</p> <p>Resident #98's current diagnoses included, but were not limited to, major depression with some psychotic features, constipation, and dementia.</p> <p>Resident #98 had a current, 10/11, physician's order for Colace 100 mg (a</p>		<p>pertinent documentation, and related follow up. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: The Director of Care Delivery or designee will conduct random medication audits on all shifts a minimum of twelve times per week to monitor for appropriate insulin administration as ordered by the physician. The Director of Care Delivery or designee will complete a review of the 24 hour report sheet and orders at least five times per week to monitor for acute change in condition and completion of pertinent documentation. The Director of Care Delivery or designee will complete a review of the residents bowel movement status to ensure timely follow up if a resident triggers for no bowel movement in 3 days and documentation of assessment. 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 into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>stool softener) one time daily.</p> <p>Resident #98 had a current 9/9/11 admission Minimum Data Set assessment (M.D.S.), which indicated the resident required limited assistance of one staff member for toileting needs.</p> <p>Review of Resident #98's electronic bowel monitoring record for 10/16/11 to 11/16/11 indicated the following:</p> <p>a.) Resident #98 had no documented bowel movements from 10/27/11 through and including 11/2/11 (a period of 7 days).</p> <p>b.) Resident #98 had no documented bowel movements from 11/6/11 through and including 11/13/11(a period of 8 days).</p> <p>Resident #98's record during the above 2 periods of time lacked any monitoring of bowel functioning or bowel sounds.</p> <p>During an 11/18/11, 1:35 p.m., interview the Director of Nursing indicated the facility had no record of the Resident #98's bowel movements or bowel functioning being monitored during the above two periods of time.</p> <p>3. The record for Resident # 85 was reviewed on 11/16/11 at 9:10 a.m.</p>		education per the QA&A process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
	<p>Computer generated bowel monitoring records for August -September 2011 indicated the resident did not have a bowel movement between 8/17/11 and 9/2/11. The form indicated the resident either did not have a bowel movement or he was marked incontinent of bowel with results coded as non-applicable.</p> <p>A hospice note, dated 8/25/11, indicated the resident had a bowel movement on 8/24/11.</p> <p>The Medication Administration Record (MAR) for August-September 2011 indicated no laxative was given until 9/2/11.</p> <p>During interview on 11/16/11 at 1:50 p.m., the Director of Nursing was queried regarding the above lack of recorded bowel movements. She indicated she was unsure as to how the bowel movements were tracked on the computer generated form and she would ask the MDS (Minimum Data Set) Coordinator.</p> <p>During interview on 11/16/11 at 3 p.m., the MDS Coordinator indicated the computer generated bowel tracking log does allow the staff to code non-applicable and incontinent. She was unable to indicate if Resident # 85 had a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>bowel movement for the days indicated above or if he had, the size and consistency of the bowel movement. She also indicated if the tracking log is coded incontinent and non-applicable it will not trigger the 3 day report for no bowel movement for follow-up.</p> <p>During an interview on 11/17/11 at 2 p.m., CNA # 25 demonstrated how to input bowel movements into the computer system. She indicated if the resident is coded incontinent, you have to put the size and consistency of the bowel movement. She indicated non-applicable should not be coded.</p> <p>4. The record for Resident # 131 was reviewed on 11/16/11 at 4 p.m.</p> <p>Computer generated bowel monitoring records for August 2011 indicated the resident did not have a bowel movement recorded between 8/26/11-8/30/11. The August 2011 Medication Administration Record (MAR) indicated no as need laxatives were given and the nursing notes between the above dates lacked any bowel assessments.</p> <p>Additional information was requested from the Director of Nursing on regarding the above lack of bowel movements on 11/16/11 at 4:30 p.m.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>On 11/17/11 at 3 p.m., during interview, the Director of Nursing indicated she had no additional information to provide regarding the lack of bowel movements</p> <p>5. Resident #141's record was reviewed on 11/15/11 at 4:30 p.m. The resident's diagnoses included, but were not limited to, dementia - Alzheimer's type, dehydration, and irritable bowel syndrome.</p> <p>The computer generated bowel monitoring record indicated the following:</p> <p>From 10/16/11 to 10/20/11, no bowel movement (BM) was indicated with "Response Not Required" indicated in the "Response" area of this form; From 11/09/11 to 11/15/11, no BM was indicated with the "Response" as "Response Not Required."</p> <p>On 11/18/11 at 1:35 p.m., during an interview, information was requested from the Director of Nursing (DON) concerning the lack of BM information.</p> <p>On 11/21/11 at 1:40 p.m. during an interview, no further information was provided by the DON concerning the resident's BM's.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>6. Resident #137's record was reviewed on 11/16/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus.</p> <p>The physician order, dated 10/15/11, was Humalog 100 units per milliliter vial inject subcutaneously (subq) per sliding scale with Accucheck blood sugar results before meals and at hour of sleep. The sliding scale for Humulog insulin was as follows: 141-180 =1 unit (u); 181 - 220 =2 u; 221 -260 = 4 u; 261 - 300 = 6 u; 301 - 340 = 7 u; 341 - 380 = 8 u; 381 - 420 = 9 u; 421 - 460 = 10 u; greater than 460 = 12 u; use 1/2 coverage at hour of sleep.</p> <p>The "Administration Record" for 10/2011 indicated for the 8:00 p.m. (schedule for hour of sleep) Accucheck results and insulin coverage as follows:</p> <p>On 10/07/11 the blood sugar (BS) result was 330 with 7 units (u) of insulin coverage given. (One half coverage was 3.5 u);</p> <p>On 10/15/11 the BS result was 310 with 7 units of insulin coverage given. (One half coverage was 3.5 u);</p> <p>On 10/16/11 the BS result was 303 with 7 u of insulin coverage given. (One half coverage was 3.5 u);</p> <p>On 10/17/11 the BS result was 310 with 7 u of insulin coverage given. (One half</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>coverage was 3.5 u); On 10/18/11 the BS result was 294 with 6 u of insulin coverage given. (One half coverage was 3 u); On 10/20/11 the BS result was 307 with 3 u of insulin coverage given. (One half coverage was 3.5 u); On 10/21/11 the BS result was 405 with 9 u of insulin coverage given. (One half coverage was 4.5 u); On 10/23/11 the BS result was 279 with 6 u of insulin coverage given. (One half coverage was 3 u); On 10/26/11 the BS result was 268 with 6 u of insulin coverage given. (One half coverage was 3 u); On 10/29/11 the BS result was 260 with 7 u of insulin coverage given. (One half coverage was 3.5 u); On 10/30/11 the BS result was 251 with 4 u of insulin coverage given. (One half coverage was 2 u); On 10/31/11 the BS result was 191 with 2 u of insulin coverage given. (One half coverage was 1 u).</p> <p>7. A 3/2010 policy titled "Medication Administration: Injections" was provided by the Director of Nursing on 11/16/11 at 1:50 p.m., and deemed as current. The policy indicated: "...prepare medications; draw up ordered amount of medication into syringe...."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>The "Geriatric Medication Handbook - Eighth Edition" indicated the following:</p> <p>"Steps of Medication Administration</p> <p>...*Accurate medication administration (i.e., right drug, right patient, right dose and dosage form, right time)...."</p> <p>A 3/2010 policy titled "Medication Administration: Injections" was provided by the Director of Nursing on 11/16/11 at 1:50 p.m., and deemed as current. The policy indicated: "...prepare medications; draw up ordered amount of medication into syringe...."</p> <p>3.1-37(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0314 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents with known pressure ulcers were provided enhanced meals, pressure reducing/relieving devices and were provided dressing changes that prevented possible contamination of the wound for 2 of 5 residents reviewed for pressure ulcer prevention and treatment in a sample of 24 (Resident #57 and #22)</p> <p>Findings Include:</p> <p>1.) Resident #57's record was reviewed on 11/15/11 at 1:00 p.m.</p> <p>Resident #57's current diagnoses included, but were not limited to, Alzheimer's disease and hypothyroidism.</p> <p>Resident #57 had a current 11/10/11 physician's order for Flagyl 25 mg and Solosite gel to open area daily cover with Tegaderm foam dressing.</p>	F0314	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Clinical record reviewed for resident #57. Staff to ensure resident receives diet as ordered to include enhanced foods. Wheelchair cushion replaced in wheelchair and staff to ensure cushion is in place per plan of care. Clinical record reviewed for resident #22. Pressure reducing devices placed on heels at the time discrepancy was noted. Treatment was applied at the time the discrepancy was noted with no negative effects to the healing process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; A chart audit was completed to identify other residents having treatment orders, enhanced food diets and pressure reducing devices. Licensed nursing staff will be educated on completion of</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Wound records on 3/31/11 indicated Resident #57's had a new 3.3 cm by 2.8 cm unstagable pressure ulcer with a necrotic wound bed and foul odor on her coccyx.</p> <p>Wound records on 11/10/11 indicated Resident #57's had a 1.1 cm by 0.3 cm by 0.2 cm pressure ulcer on her coccyx.</p> <p>Resident #57 had a current, 4/13/11 care plan problem/need regarding an open area to the coccyx. Approaches to this problem were apply treatment as ordered, gel cushion to the wheelchair and provided enhanced food.</p> <p>During an 11/17/11, 11:00 a.m., pressure area wound treatment observation the following concerns were observed: a.) LPN #14 washed her hands for only 8 seconds and applied gloves. b.) LPN #14 removed the soiled dressing and with the same soiled gloves, washed and flushed the wound. c.) After cleansing the wound, LPN #14 removed her gloves, did not wash her hands, applied new gloves and completed the treatment.</p> <p>During an 11/15/11, 12:30 p.m., observation, Resident #57 was seated in her wheel chair with no gel cushion in the wheelchair. During an interview at this</p>		<p>treatments as ordered by the physician. Nursing and Dietary staff will educated on providing diet per physicians order. Dietary staff will be educated on following the diet spreadsheet including providing indicated enhanced items. Nursing staff will be educated on availability and placement of pressure reducing devices as ordered by the physician. Nursing staff will be educated on proper handwashing when providing care and services to residents. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: Director of Care Delivery or designee will observe handwashing on at least 10 staff per week for proper techniques per facility guideline. Director of Care Delivery or designee will validate placement and use of pressure reducing devices at least weekly per resident plan of care. Director of Care Delivery or designee will observe treatment changes at least 4 times per week to validate placement and technique per guidelines. The Food Service Director, Registered Dietitian or designee will complete random breakfast, lunch and dinner tray audits a minimum of 3 days per week to validate that residents are receiving meals as ordered by the physician. How the corrective action(s) will be monitored to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>same time, LPN #15 indicated Resident #57 was supposed to have a gel cushion in her wheelchair.</p> <p>During a 11/15/11, 12:50 p.m., lunch meal observation, Resident #57 was not served an enhanced food item with her meal, nor was any enhanced food item served during the remainder of the meal.</p> <p>During an 11/17/11, 7:45 a.m. observation, Resident #57 was seated in her wheelchair without a gel cushion in the seat. During an interview at this time, LPN #14 indicated Resident #57 should have a gel cushion in her wheelchair seat. During an interview on 11/17/11 at 8:15 a.m., CNA #16 indicated she had been responsible for transferring Resident #57 into her wheelchair that morning and because the cushion was not in the wheelchair when she transferred her she did not seek a cushion to place in the chair.</p> <p>2. On 11/15/11 from 10:26 a.m. to 10:55 a.m., during initial tour with the Director of Care Delivery (DCD) #1, Resident #22 was observed in her bed. Her right bootie was observed off and was presently reapplied by DCD #1.</p> <p>On 11/16/11 at 10:30 a.m., Resident #22</p>		<p>ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**Will the Director of Care Delivery observe hand washing techniques on ten staff members weekly on all shifts? Will the Director of Care Delivery observe placement and use of pressure reducing devices weekly on all shifts?The Director of Care Delivery or designee will observe hand washing techniques on at least 10 staff per week on all shifts for proper techniques per facility guideline. The Director of Care Delivery or designee will observe placement and use of pressure reducing devices at least weekly on all shifts per resident plan of care.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>was observed in bed with one bootie off. At this same time during an interview, CNA 7 indicated she should have the bootie on and reapplied it at this time.</p> <p>On 11/16/11 from 1:50 p.m. to 2:20 p.m., Resident #22's personal care was observed. After CNA #7 donned a pair of gloves and prepared her supplies, she indicated the resident's peri-area was wet. At this same time during an interview, CNA #7 indicated the resident's Foley catheter was not leaking. After the resident was turned, no dressing was observed on her coccyx open area. The Chux (disposable underpad) under the resident was observed with a large dinner plate sized wet area. The resident's buttocks were also observed with a red-like rash around the open area. As CNA #7 cleansed the rectal area, the resident had been incontinent of a small amount of soft, brown bowel movement. The resident's personal care was then completed. At this same time during an interview, CNA #7 indicated she had reported the no dressing to the nurse. She also indicated she had last checked the resident this a.m. between 8 a.m. and 9 a.m. She indicated she was not sure if the dressing was on the open area or not, but the Chux had been a "little" wet at that time.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>On 11/16/11 at 3:25 p.m., during an interview, LPN #9 indicated she had been told about Resident #22's lack of her coccyx dressing. She indicated she had thought LPN #10 had dressed the open area.</p> <p>On 11/16/11 at 3:28 p.m., during an interview, LPN #10 indicated she was not aware Resident #22 did not have a dressing on her open coccyx area. She indicated she had changed it last night, and the resident was then given a shower and could had come off then. She indicated she had to get her medications passed presently and would do the dressing change after she finished passing her medications.</p> <p>On 11/16/11 at 4:10 p.m., the Director of Nursing (DON) was informed Resident #22's did not have a dressing over her open coccyx area. The DON notified the DCD #1, and the treatment and dressing to the coccyx area was completed.</p> <p>Resident #22's record was reviewed on 11/16/11 at 1:05 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus - insulin dependent, depression/anxiety, and chronic obstructive pulmonary disease.</p> <p>The physician order, dated 9/07/11, was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>heel boots bilateral lower extremities except during activity of daily living care.</p> <p>The "NURSE'S NOTES" indicated the following:</p> <p>On 11/10/11 at 8:00 a.m., the readmission wound evaluation was a Stage IV to the coccyx and measured 4.4 centimeters (cm) by 3.5 cm by 0.5 cm.; serosanguineous drainage; 50% necrotic and 50% granulated with wound edge attached; tunneling noted at 10 p.m. and measured 0.4 cm.</p> <p>On 11/17/11 at 6:45 a.m., the coccyx wound measured 3.5 cm by 3.8 cm by 1.5 cm; moderate amount of serous drainage with 20% slough and 80% granulation with the wound edge attached; tunneling was at 9:00 p.m. and measured 0.6 cm. Incontinent dermatitis was noted to peri-area and surrounding areas to coccyx.</p> <p>3. Review of a current, facility policy and procedure titled "Skin Process Flow", which was proved by the Director of Nursing on 11/17/11 at 10:55 a.m., indicated the if a resident has a pressure area the facility should develop a "Medical Care Imitative"; the care plan should be developed and revised as needed; care plans should be "Implemented."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
F0315 SS=E	<p>3.1-40(a)(2)</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review, observation and interview, the facility failed to ensure residents with anchored catheters were provided care to prevent the possibility of infection for 5 of 6 resident's observed with anchored catheters in the sample of 24. (Resident # 85, # 50, # 20, # 73 and # 22)</p> <p>In addition, the facility failed to ensure 2 of 6 residents with anchored catheters had a diagnoses for use or were discontinued timely in the sample of 24. (Resident # 85 and # 137)</p> <p>The facility also failed to ensure perineal care was provided in a manner to prevent the possibility of infection for 3 of 3 residents observed for perineal care in a sample of 24 (Resident # 94, #141 and #22).</p>	F0315	<p>INFORMAL DISPUTE RESOLUTION F315 483.25(d)</p> <p>Urinary Incontinence <i>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible</i> The facility respectfully denies and disputes the allegation that it was deficient with regard to F315; in terms of residents #20 and #73 and requests that residents #20 and #73 be deleted from the public</p>	12/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Findings include:</p> <p>1. The record for Resident # 85 was reviewed on 11/16/11 at 9:10 a.m.</p> <p>Current physician orders for November 2011 lacked an order for an anchored catheter or justification for use.</p> <p>A physician order, dated 11/8/11, indicated an order for Cipro (antibiotic) 500 milligrams twice daily for 10 days for a urinary tract infection.</p> <p>A Nurse Practitioner progress note, dated 11/15/11, indicated the resident was seen in the emergency room on 11/8/11 and was diagnosed with a urinary tract infection. The note indicated the antibiotic was changed to Invanz (antibiotic) 1 gram intravenously for 10 days on 11/15/11.</p> <p>A plan of care, dated 11/10/11, indicated a problem of urinary tract infection.</p> <p>During a care observation on 11/15/11 at 3:40 p.m., CNA # 17 retrieved the resident's anchored catheter bag and tubing from the dignity bag under the wheelchair. She then placed the catheter bag and tubing onto the resident's lap, above the level of the bladder. The</p>		<p>record for reasons set forth herein. The statement of deficiency cites that residents #20 and #73 were observed with catheter tubing and/or bag on the floor. There is no clinical evidence that indicates catheter tubing being on the floor as a cause of urinary tract infections. We respectfully request that resident #20 and #73 be deleted from the public record. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Clinical record review was completed for resident #85. An order and diagnosis was obtained to support the ongoing use of the anchored catheter. Resident currently has no signs or symptoms of a urinary tract infection. Clinical record review was completed for resident #50. Resident currently has no signs or symptoms of a urinary tract infection. Tubing placement was satisfactorily addressed at the time the deficient practice was noted. Clinical record review was completed for resident # 20. Resident currently has no signs or symptoms of a urinary tract infection. Tubing placement was satisfactorily addressed at the time the deficient practice was noted. Clinical record review was completed for resident #94. Resident currently has no signs or symptoms of a urinary tract infection. Clinical record review</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>catheter bag and tubing remained on the resident's lap for the duration of the Hoyer transfer; the drainage bag and tubing had urine in them. After the resident was placed in bed, CNA # 18 drained the catheter tubing and the drainage bag was lying on the floor.</p> <p>During interview on 11/16/11 at 2 p.m., LPN #11 indicated the resident had not had a diagnoses or justification for his anchored catheter prior to this date.</p> <p>2. The record for Resident # 50 was reviewed on 11/18/11 at 10:30 a.m.</p> <p>Current physician orders for November 2011, indicated the resident had an anchored catheter.</p> <p>A physician order, dated 11/3/11, indicated the resident was placed on an antibiotic Cipro 500 milligrams twice daily for 7 days for the treatment of a urinary tract infection.</p> <p>A physician order, dated 7/17/11, indicated an order for an antibiotic Tobramycin 90 milligrams intravenously every 12 hours for the diagnoses of a urinary tract infection.</p> <p>On 11/16/11, at 9 a.m., the resident was sitting in his wheelchair in the main</p>		<p>was completed for resident #141. Resident currently has no signs or symptoms of a urinary tract infection. Clinical record review was completed for resident #22. Resident currently has no signs or symptoms of a urinary tract infection. Clinical record review was completed for resident #137. The foley catheter was removed. The physician was made aware of delay of removal with no new orders received. Resident #73 no longer resides in the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; A chart audit was completed to identify other residents having anchored catheters to ensure appropriate diagnosis for use, proper positioning of tubing, proper perineal and catheter care per facility guidelines. Licensed staff will be educated on guidelines for foley catheter use and management. Certified nursing staff will be educated on the guidelines for proper perineal and catheter care. Nursing staff will be educated on proper handwashing when providing care and services to residents. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: Director of Care Delivery</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>dining room with his anchored catheter tubing on the floor under his wheelchair. There was urine in the tubing. At that time, CNA # 19 was informed of the tubing position and she corrected the tubing and moved it off the floor.</p> <p>3. The record for Resident # 20 was reviewed on 11/18/11 at 11 a.m.</p> <p>Current physician orders for November 2011 indicated the resident had an anchored catheter on 10/29/11.</p> <p>A (name of hospital) discharge summary, dated 10/28/11, indicated the resident was admitted 10/27-28/11 for the diagnosis of a urinary tract infection. She was discharged on the antibiotic Levafloxacin 250 milligrams daily for 7 days.</p> <p>On 11/18/11 at 8:20 a.m., the resident was in her wheelchair in the main dining room. Her anchored catheter tubing was on the floor under her wheelchair. There was urine in the tubing. At that time CNA # 20 was informed of the tubing placement and adjusted the tubing off the floor without wearing gloves for washing her hand before or after.</p> <p>4. The record for Resident # 94 was reviewed on 11/16/11 at 2 p.m.</p>		<p>or designee will observe handwashing on at least 10 staff per week for proper techniques per facility guideline. Director of Care Delivery or designee will observe proper care and cleaning of anchored catheters a minimum of 10 times per week. The Director of Care Delivery or designee will complete a review of the 24 hour report sheet and orders at least five times per week to monitor for new orders for placement of anchored catheters to ensure there is an appropriate diagnosis to support use of the anchored catheter. 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 into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**Will the Director of Care Delivery observe hand washing techniques on 10 staff members weekly on all shifts? Will the Director of Care Delivery observe proper care and cleaning of anchored catheters 10 times weekly on all shifts?The Director of Care Delivery or designee will observe hand washing</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Current diagnoses included, but were not limited to, urinary tract infection.</p> <p>A 9/27/11 laboratory report indicated the resident had Escherichia coli in the urine.</p> <p>A physician's order, dated 9/30/11, indicated the resident had an order for an antibiotic Septra DS (double strength) twice daily for 10 days for the treatment of a urinary tract infection.</p> <p>A CNA task sheet, dated 11/18/11, indicated the resident was to be checked for incontinence frequently and provide incontinent care as needed.</p> <p>During a care observation on 11/16/11 at 9:50 a.m., the resident was placed in bed and covered up. CNA # 21 was queried if the resident would be checked for incontinence at this time. She indicated the resident had just been changed. At 10:05 a.m., LPN #11 was informed the resident was placed into bed and no incontinence care was provided. At 10:10 a.m., CNA # 21 returned to the resident's room and provided incontinence care. She removed the resident's wet brief and while the resident was on her side, she washed the resident's rectal area. The clean brief was applied and the care was completed. CNA # 21 did not provide care to the front perineal area. After the</p>		<p>techniques on at least 10 staff per week on all shifts for proper techniques per facility guideline. The Director of Care Delivery or designee will observe proper care and cleaning of anchored catheters a minimum of 10 times per week on all shifts.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>observation, the CNA during interview, indicated to provide pericare, she would wipe between the legs to the back side with one wipe.</p> <p>5. On 11/15/11 from 1:44 p.m. to 1:50 p.m., Resident #141's personal care was observed. At this same time during an interview, CNA #5 indicated the resident had been incontinent of urine. With wipes, CNA #5 was observed to cleanse the resident by wiping across the top of the peri-area, down one side and around the bottom of the peri-area, and up the other side. No cleansing of the vulva was observed as the resident was turned, and rectal care was completed.</p> <p>On 11/16/11 at 1:40 p.m., during an interview, CNA #5 indicated one should cleanse from the front to the back when doing peri-care for a female.</p> <p>Resident #141's record was reviewed on 11/15/11 at 4:15 p.m. The resident diagnoses included, but were not limited to, dementia - Alzheimer's type.</p> <p>The physician order, dated 11/09/11, was Cipro (antibiotic) 250 milligrams take 1 every 12 hours for 7 days.</p> <p>The physician order, dated 11/10/11, was Amoxicillin (antibiotic) 500 milligram</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
	<p>take 1 every 8 hours for 10 days due to urinary tract infection and to discontinue the Cipro.</p> <p>The laboratory study, dated 11/08/11, indicated a "PRELIMINARY REPORT" with a growth of Enterococcus species.</p> <p>6. On 11/16/11 from 1:50 p.m. to 2:20 p.m., Resident #22's personal care was observed. After CNA #7 donned a pair of gloves and prepared her supplies, she indicated the resident's peri-area was wet. At this same time during an interview, CNA #7 indicated the resident's Foley catheter was not leaking. After the resident was turned, no dressing was observed on her coccyx open area. The Chux (disposable underpad) under the resident was observed with a large dinner plate sized wet area. As CNA #7 cleansed the rectal area, the resident had been incontinent of a small amount of soft, brown bowel movement. After completing the rectal care, CNA #7 left the room. After telling the nurse about the lack of a dressing, CNA #7 returned to the room and indicated she needed to complete the resident's care. With gloved hands, she was observed to cleanse each side of the resident's thighs several times with no cleansing of the vulva or Foley catheter tubing. After turning the resident, she then cleansed the rectal area</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>to complete her care. At this same time during an interview, CNA #7 indicated she did not always clean the catheter tubing or around it.</p> <p>On 11/16/11 from 4:15 p.m. to 4:40 p.m., Resident #22's coccyx dressing change was observed. After completing the dressing change, LPN #9 and DCD #1 proceeded to reposition the resident. In preparation, LPN #9 removed the Foley catheter (F/C) bag from the bed's frame holding it above the bladder level as the decision was made concerning which side the resident was to be turned. Yellow, cloudy urine was observed in the F/C tubing and bag. When DCD #1 indicated which side the resident was to be turned, the F/C bag was switched to the opposite side and lowered and positioned below the resident's bladder.</p> <p>Resident #22's record was reviewed on 11/16/11 at 1:05 p.m. The resident's diagnoses from the hospital stay from 10/30/11 to 11/04/11 included, but were not limited to, diabetes mellitus - insulin dependent and urosepsis with Proteus mirabilis.</p> <p>7. On 11/18/11 at 8:15 a.m., Resident #137 was observed in bed with the Foley catheter in place. Cloudy, yellow urine with sediment was observed in the Foley</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>catheter tubing.</p> <p>Resident #137's record was reviewed on 11/16/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, dementia and insulin dependent diabetes mellitus.</p> <p>The physician order, dated 11/17/11, was to discontinue the Foley catheter.</p> <p>The nurse's notes indicated the following:</p> <p>On 11/20/11 at 4:45 p.m., the resident had a Foley catheter.</p> <p>On 11/21/11 at 11:00 a.m., the anchored Foley catheter was removed at this time.</p> <p>On 11/12/11 at 2:25 p.m., during an interview, the Director of Nursing indicated she did not know why the Foley catheter had not been taken out as ordered.</p> <p>8.) Resident #73's record was reviewed on 11/15/11 at 11:15 a.m.</p> <p>Resident #73's current diagnoses included, but were not limited to, dementia and kidney disease.</p> <p>Resident #73 had a current, 10/11, physician's order for an anchored catheter.</p> <p>Resident #73 had a current, 11/6/11, care</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>plan problem/need regarding the need for an indwelling catheter. A goal for this problem was to have no acute complications related to catheter use.</p> <p>During an observation on 11/15/11 at 1:40 p.m., Resident #73 was in bed. His catheter bag was on the floor.</p> <p>9. A 12/2009 policy title "Incontinence Care" was provided by the Director of Nursing on 11/17/11 at 10:55 a.m., and deemed as current. The policy indicated: "...Cleanse peri area and buttocks with a cleansing agent wiping from front of perineum toward rectum. Turn patient side to side to cleanse the entire affected area, as needed...Dry peri-area and buttocks from front to back...."</p> <p>10. A 11/2011 policy titled "Catheter insertion: Indwelling and Straight" was provided by the Director of Nursing on 11/17/11 at 10:55 a.m., and deemed as current. The policy indicated: "...Secure urinary drainage bag to bed frame below the level of the bladder and off floor...."</p> <p>3.1-41(a)(1) 3.1-41(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

F0322 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on interview and record review, the facility failed to ensure a resident receiving a gastrostomy tube feeding was being checked for gastric content in the prevention of complications related to vomiting and/or aspiration pneumonia for 1 of 3 residents reviewed with gastrostomy/feeding tube in a sample of 24. (Resident #137)</p> <p>Findings include:</p> <p>Resident #137's record was reviewed on 11/16/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, dementia, gastroesophageal reflux disease, and a history of aspiration pneumonia.</p> <p>The physician order, dated 10/17/11, was Glucerna 1.2 at a rate of 95 milliliters (ml) per hour to start at 12:00 p.m. and run until 1900 ml had infused.</p> <p>The physician order, dated 11/10/11, was</p>	F0322	<p>INFORMAL DISPUTE RESOLUTION F322 483.25(g)</p> <p>(2) Naso Gastric Tubes A</p> <p><i>resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills</i> The facility respectfully denies and disputes the allegation that it was deficient with regard to F322 and requests that the deficiency identified as F322, be deleted from the public record for reasons set forth herein. The statement of deficiency cites that the facility failed to ensure that resident #137; who has a gastrostomy tube feeding was being checked for gastric content in the prevention of complications related to vomiting and/or aspiration pneumonia. Resident #137 did have an order dated 10/15/11, to check gastric residual before feeding and as clinically indicated. If greater then 400 millimeters and there were no</p>	12/21/2011
---------------	--	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Glucerna 1.2 at 90 ml per hour to start at 12:00 p.m. and run until 1800 ml had infused.</p> <p>The physician order, dated 10/15/11, was to check gastric residual before feeding and as clinically indicated. If greater than 400 milliliter (ml) and there were no symptoms refeed residual and continue to feed patient. In 4 hours recheck residual. If second residual was greater 400 ml, do not refeed residual, hold feeding and notify physician.</p> <p>The "Administration Record" for 11/2011 indicated checking for residual was an "FYI (for your information)." No information was indicated on this record related to residual in the resident's gastrostomy tube was being checked.</p> <p>The "Nurses Notes" indicated the following:</p> <p>On 11/01/11 at (illegible) a.m., resident's gastrostomy tube (G-tube) was patent, flushed with ease, and infusing feeding without difficulty.</p> <p>On 11/01/11 at 7:30 a.m., the resident was vomiting and coughing. The feeding was turned off, and the resident was suctioned.</p> <p>On 11/01/11 at 8:45 a.m., with the Nurse Practitioner present the resident vomited and was suctioned. The resident was sent</p>		<p>symptoms refeed residual and continue to feed patient. In 4 hours recheck residual. If second residual was greater 400 milliliters do not refeed residual, hold feeding and notify physician (attachment #1). The statement of deficiency goes on to cited nurses notes of identified changes in the resident related to emesis. "GRV's (gastric residual volume) should always be interpreted along with a careful history for symptoms of intolerance (bloating, abdominal pain nausea, vomiting) and a careful bedside physical exam (physical signs of intolerance such as abdominal distention, vomiting, and failure to pass stool or gas). Because a high GRV has been shown to be an isolate event 80% of the time, a single high, GRV above any designated "cutoff" value should not be used for automatic cessation of EN (enteric nutrition). It is appropriate for a single high value to initiate a series of steps to reduce further risk, but an order for automatic cessation should be applied very carefully and probably only after a second high value 4-6 hours later is obtained." Carol Rees Parrish & Stephen A. McClave(attachment #2). A review of the attached nurses notes clearly indicates that ongoing evaluation was present during the feeding with action taken timely when changes occurred (attachment # 3) In</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>to the emergency room.</p> <p>On 11/09/11 at 1:00 p.m., the resident returned from the hospital. The G-tube flushed without difficulty.</p> <p>On 11/10/11 at 8:45 p.m., the current feed order was 70 milliliters per hour to feed a total of 1900 milliliter.</p> <p>On 11/15/11 at 9:25 a.m., the resident was having brown colored emesis. The "Nurse Reactionary [sic]" was notified, and the feeding was held for 2 hours.</p> <p>On 11/16/11 at 12:45 p.m., the resident had emesis 1 time.</p> <p>On 11/16/11 at 1:40 p.m., the physician was notified of the emesis, and the feeding was to be held for 24 hours.</p> <p>On 11/18/11 at 1:00 a.m., the G-tube feeding was patent and infusing without difficult.</p> <p>On 11/18/11 at 12:00 p.m. during an interview, LPN #40 indicated she would check residual before giving the resident his medications. LPN #40 also indicate she would check for residual before she would start his tube feeding. She indicated she would only document if the resident had residual.</p> <p>On 11/21/11 at 9:40 a.m. during an interview, the Director of Nursing indicated she had no further information concerning the checking of the resident's residual.</p>		<p>addition the statement of deficiency confirms through interview with LPN #40 that residual is checked before tube feeding is started and before medications are given and would document if the resident had residual. This is consistent with the physician orders and the Charting: Nursing Documentation guidelines (attachment #4). In summary resident #137 does receive tube feeding through gastrostomy tube and the facility is following the orders for checking residual. Documentation would be present in the event that the gastric residual is greater then 400 milliliters with second check and the feeding needed to be held and physician notified. Documentation clearly supports on going evaluation and action taken based on findings. We respectfully request that F322 be deleted from the public record.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Clinical record review was completed for resident #137. The medication administration record was updated to include documenting of residual checks.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; A chart</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>The "Enteral Tubes: Continuous (pump) Feedings" was provided by the Director of Nursing on 11/21/11 at 9:40 a.m. This current policy indicated the following:</p> <p>"Purpose: To describe the procedure for administering intermittent enteral feedings via pump method</p> <p>...Procedure: ...12. Verify enteral tube placement and residual checks per physician order...."</p> <p>3.1-44(a)(2)</p>		<p>audit was completed to identify other residents with a gastric tube. Residents with a gastric tube will be checked for gastric content in the prevention of complications related to vomiting. Licensed staff will be educated on guidelines for enteral tube care to include assessment and documentation. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: The Director of Care Delivery or designee will observe appropriate assessment of and documentation related to gastric content for residents with gastric tubes least five times per week. 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 into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**Will the Director of Care Delivery observe appropriate assessment of documentation related to gastric content for residents with G tubes five times weekly on all shifts?</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
--------------------	--	---------------	---	----------------------

F0323 SS=E	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review, observation and interview, the facility failed to ensure a resident was transferred safely to prevent a fall for 1 of 3 observed transfers (Resident # 94); failed to ensure safety alarms were on and functioning for 2 of 2 residents observed with alarms (Resident # 73 and # 141); failed to ensure smoking assessment were completed timely for 2 of 2 residents reviewed for smoking assessments (Resident # 19 and # 104) in a sample of 24, and failed to ensure a medication room was secured for 1 of 3 medication rooms observed. This deficit practice had the potential to affect 19 of 149 residents residing in the front of the building.</p> <p>Findings include:</p> <p>1. The record for Resident # 94 was reviewed on 11/16/11 at 2 p.m.</p> <p>Current diagnoses included, but were not</p>	F0323	<p>The Director of Care Delivery or designee will observe appropriate assessment of and documentation related to gastric content for residents with gastric tubes least five times per week on all shifts.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Clinical record review was completed for resident #94. There were no further incidents related to the sited observation. Staff to ensure care is provided per plan of care. Clinical record review was completed for resident #19 and #104. Smoking evaluations were completed for both residents. Clinical record review was completed for resident #141. The bed alarm was replaced. There were no further incidents related to the sited observation. Staff to ensure care is provided per plan of care. No residents identified for the intermediate medication room door left open and unsupervised. The door was shut and secured at the time of observation. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	12/21/2011
---------------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>limited to, Alzheimer's Disease and Arthritis.</p> <p>A plan of care with a revision date of 6/17/10, indicated the resident was at risk for falls due to multiple chronic conditions including, but not limited to, impaired gait, poor coordination, left arm amputation with approaches that included, but were not limited to, transfer with assist of 2 persons.</p> <p>A CNA task sheet provided by the Director of Nursing on 11/18/11 at 8:40 a.m., indicated the resident was to be transferred with assist of 2 persons with extensive assist and to use a gait belt.</p> <p>During a care observation on 11/16/11 at 9:50 a.m., CNA # 21 took the resident to her room. She then removed the resident's blankets and sweater. She then requested the resident to give her a hug. The resident placed her one arm around the CNA and the CNA then lifted the resident from the wheelchair to the bed. The resident was not positioned far enough back on the bed, so the CNA attempted to lift her back. At that time, the resident began slipping to the floor. The CNA the lowered the resident to the floor. She attempted to pick up the resident. Help was summoned. The CNA had a gait belt in the pocket of her</p>		<p>actions will be taken; A chart audit was completed to identify other residents that need assistance with transfers and fall prevention devices to ensure services are provided per plan of care. A chart audit was completed to identify current smokers. Smoking evaluations were reviewed and updated per facility smoking guidelines. All residents have the potential to be effected by the medication room door left open and unsupervised. Certified nursing staff will be educated on guidelines for transfers and following the resident plan of care. Nursing staff will be educated on guidelines for fall prevention including the proper use of safety alarms. Facility staff will be education on the facility smoking guidelines. Licensed staff will be educated on the proper storage of medication and supplies to include maintaining a secured medication room. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: The Director of Care Delivery or designee will conduct observations at least five times per week to ensure staff are following residents plan of care for assistance and proper resident transfers. The Director of Care Delivery or designee will conduct observations at least five times per week to ensure fall prevention devices are utilized</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>The resident's original admission date was 7/22/11.</p> <p>The "Social Services Department Progress Notes," dated 9/26/11, indicated the resident was observed outside smoking "out of policy." The smoking policy was reviewed with the resident.</p> <p>The care plan with an initiated date of 9/27/11 indicated a history of smoking in community and non compliance with facility policy. The interventions included, but were not limited to, observe for compliance with smoking plan and report noncompliance or viewed unsafe practices; reassess as needed.</p> <p>On 11/21/11 at 10:40 a.m., during an interview, Social Service Director #42 indicated a smoking evaluation was not found on Resident #19 and Social Service Director #41 was completing one now.</p> <p>On 11/21/11 at 10:55 a.m., during an interview, Social Service Director #41 indicated she did not find a smoking evaluation for Resident #19. The resident was evaluated today and was determined to be at risk as a smoker requiring staff, family, friend for physical support or supervision to smoke.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>3. Resident #104's record was reviewed on 11/18/11 at 8:45 a.m. The resident's diagnoses included, but were not limited to, quadriplegic, depression, epilepsy, agitation, bipolar, and a smoker.</p> <p>The resident was admitted to the facility on 8/31/09.</p> <p>The most recent "Smoking Evaluation was 3/08/10. The resident was indicated as being noncompliant at times with to smoke only in the designated smoking areas at the designated times; to keep all smoking accessories when not in use under the control of the center staff; and be able to communicate the safety risks associated with smoking. The resident did use adaptive equipment. Also, The resident was evaluated today and was determined to be at risk as a smoker requiring staff, family, friend for physical support or supervision to smoke.</p> <p>The "Social Services Department Progress Notes" indicated the following:</p> <p>On 7/21/11 and on 8/18/11, the record indicated the resident continued to be noncompliant with the smoking policy at times with no specifics indicated.</p> <p>On 6/16/11, the resident was reminded of the smoking policy and the need to give all cigarettes to nursing.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>No further information was indicated concerning a smoking evaluation with the noncompliant smoking episodes.</p> <p>On 11/21/11 at 10:40 a.m. during an interview, Social Service Director #42 indicated the last smoking evaluation for Resident #104 was on 3/08/10. She indicated an evaluation should had been done when the resident was found to be noncompliant.</p> <p>The "Smoking Guidelines" policy was provided by the Director of Nursing on 11/21/11 at 9:40 a.m. This current policy indicated the following:</p> <p>"PURPOSE: To determine if a patient is an Independent Smoker or an At Risk Smoker before the patient exercises the privilege to smoke while residing within the center and to establish smoking guidelines for all patients that desire to smoke in the center.</p> <p>GUIDELINES:</p> <p>...*Evaluate patients that smoke utilizing the [Smoking Evaluation] tool either: (a) upon admission; ...(c) if unsafe smoking practices are observed in a current smoker...."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>4. On 11/15/11 from 10:26 a.m. to 10:55 a.m., during initial tour with the Director of Care Delivery (DCD) #1, Resident #141 was observed in her bed. When her bed alarm was checked, DCD #1 indicated it was not functioning. DCD #1 then proceeded to correct the malfunctioning bed alarm.</p> <p>On 11/15/11 at 1:00 p.m., Resident #141 was observed in the dining room in her wheelchair awaiting her lunch tray. Her personal body alarm was observed on her wheelchair and functioning. The connecting cord to the alarm were observed with a loosely formed knot in it. Under this knot the wires were observed to be exposed.</p> <p>On 11/15/11 from 1:44 p.m. to 1:50 p.m., Resident #141's personal care was observed. After her care was completed, CNA #5 proceeded to leave the room. At this same time during an interview, CNA #5 indicated he had not checked her bed alarm. He returned to the room and turned on the bed alarm, which was then observed to be functioning.</p> <p>On 11/15/11 at 6:20 p.m., Resident #141 was observed in bed. At this same time, after LPN #6 was notified of the exposed wires on the resident's personal body alarm on her wheelchair, she indicated the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>alarm should be replaced. Also at this same time, as the bed alarm was observed not functioning by the green blinking light, DCD #1 checked the bed alarm and indicated she had turned it on. She also indicated the exposed wires on the wheelchair alarm could be why the alarm had been "shorting out."</p> <p>On 11/16/11 at 10:20 a.m., Resident #141 was observed in her bed.. At this same time during an interview, CNA #7 checked the resident's bed alarm and indicated it was not turned on. After she turned it on, the bed alarm was observed to be functional with the battery not covered.</p> <p>On 11/16/11 at 1:40 p.m., Resident #141 was observed in bed with the bed alarm not functioning. At this same time during an interview, CNA #5 indicated the family would put the resident to bed at times and did not turn on the resident's bed alarm. CNA #5 proceeded to turn the bed alarm on at this time.</p> <p>Resident #141's record was reviewed on 11/15/11 at 4:30 p.m. The resident's diagnoses included, but were not limited to, dementia - Alzheimer's disease.</p> <p>The care plan, initiated on 12/28/2010, indicated the focus included the resident</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>was at risk for falls due to cognitive impairment, poor safety awareness, and use of psychotropic medications. The interventions included, but were not limited to, ensure that bed/chair alarm is in place when in bed and/or wheelchair.</p> <p>The fall history indicated the resident had falls without injuries on 2/10/11 at 11:00 a.m., on 3/26/11 at 2:45 p.m., and on 8/119/11 at 9:11 a.m.</p> <p>No information was indicated concerning if an alarm was in place and/or functioning.</p> <p>5.) Resident #73's record was reviewed on 11/15/11 at 11:15 a.m.</p> <p>Resident #73's current diagnoses included, but were not limited to, dementia and kidney disease.</p> <p>Resident #73 had a current 11/5/11 care plan problem regarding the potential for falls. An approach to this problem was to use an alarm in the wheelchair and bed.</p> <p>Resident #73's record indicated he had falls without injuries on 11/9/11, 11/10/11, 11/11/11 and 11/15/11. The falls did not indicate alarm functioning was a component of the fall.</p> <p>During an 11/17/11, 7:43 a.m.,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>observation, Resident #73 was in bed. The cord from the bed alarm was on the floor and not attached to an alarm sounding box. During an interview at this time, LPN #31 indicated she could not find Resident #73's alarm. She then searched the room and found the alarm attached to the resident's wheelchair. LPN #31 indicated Resident #73 should have an alarm on both the wheelchair and his bed.</p> <p>6.) During an observation on 11/18/11, 7:34 a.m., the front building Intermediate unit medication room door was propped open with two large plastic totes. There were no facility staff members in the area. A nurse was summonsed at 7:40 a.m. LPN #11 came to the area at that time. LPN #11 indicated the door to the medication room should never be propped open and indicated a sign, which was posted on the door which clearly indicated the medication room door may not be propped open. Accompanied by LPN #11, the contents of the medication room were reviewed at this time. The medication room contained a refrigerator that contained refrigerated medications such as suppositories, insulin and an refrigerated Emergency Drug Kit. On the counter were an Intravenous Emergency Drug Kit and a standard Emergency Drug Kit. In the cabinet were syringes, extra</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Milk of Magnesia, Saline and medical care kits.</p> <p>Review on a facility form titled "Normal Med Room Supplies" which were provided by the Director of Nursing, on 11/21/11 at 9:40 a.m., indicated the medications rooms normally contain, "overflow medications; medications to be returned to the pharmacy; IV saline flushes; syringes; Accucheck supplies; Med cart supplies-spoons, med cups, drinking cups; IV meds & supplies; suppositories; refrigerated medications; TB solution..."</p> <p>Review of a current facility form titled "Injectable Emergency Drug Kit Medications" (EDK), which was provided by the Director of Nursing on 11/12/11 at 9:40 a.m., indicated the 41 medications were contained in the Injectable EDK which included, but were not limited to: Haldol, Lovenox, Narcan and Heparin.</p> <p>Review of a current facility form titled "Emergency Medications-Controlled Substances (inside EDK) and Refrigerator box", was provided by the Director of Nursing on 11/12/11 at 9:40 a.m., indicated 30 "controlled" medications were inside the EDK kit and 10 medications were in the refrigerator kit. These medications included, but were not</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0328 SS=D	<p>limited to: Ambien, Ativan, Duragesic patches, Valium, and Vicodin.</p> <p>Review of a current facility form titled, "Emergency Drug Kit Medications- Brand Name", which was provided by the Director of Nursing on 11/12/11 at 9:40 a.m., indicated 128 medication were contained in the EDK kit, which included, but were not limited to: Coumadin, Flexeril, Haldol, Seroquel and Risperdal.</p> <p>Review of a current, 11/18/11, facility form titled "Resident Response Analyzer" which was provided by the Director of Nursing on 11/21/11 at 9:40 a.m., indicated 19 residents in the front building were the intermediate unit was located were cognitively impaired and mobile.</p> <p>3.1-45(a)(1)</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review and observation,</p>	F0328	What corrective action(s) will	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011			
(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			
	<p>the facility failed to ensure pre and post respiratory treatments were completed and failed to ensure the nebulizer medication dispenser was cleaned after use for 2 of 2 nebulizer treatments observed in a sample of 24. (Resident # 85 and # 96)</p> <p>Findings include:</p> <p>1. The record for Resident # 85 was reviewed on 11/16/11 at 9:10 a.m.</p> <p>Current diagnosed included, but were not limited to, Pneumonia and Cerebral Palsy.</p> <p>Physician orders for November 2011 indicated an order for Duoneb three times daily per nebulizer.</p> <p>On 11/15/11 at 12:15 p.m., LPN # 12 was observed to prepare Resident # 85's Duoneb medication. She initiated the treatment by placing the nebulizer dispenser onto the resident's tracheostomy mask. She turned on the machine. While the treatment infused, LPN # 12 stayed in the room. She did not assess the resident's lung sounds, pulse or oxygen saturation before, during or after the treatment. When the treatment was completed, she unhooked the medication dispenser and bagged it. She did not rinse the medication dispenser cup.</p>		<p>be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Clinical record review was completed for resident #85. The medication administration record was updated to include pre and post assessment of heart rate and lung sounds. The tubing and cup was replaced with clean supplies.</p> <p>Clinical record review was completed for resident #96. The medication administration record was updated to include pre and post assessment of heart rate and lung sounds. The tubing and cup was replaced with clean supplies.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart audit was completed to identify other residents who currently receive nebulizer treatments as part of the plan of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>2. The record for Resident # 96 was reviewed on 11/18/11 at 12 p.m.</p> <p>Current physician orders indicated an order for Albuteral nebulizer treatment four times daily.</p> <p>On 11/18/11 at 4:30 p.m., LPN # 13 was observed to prepare Resident # 96's nebulizer treatment. She initiated the treatment after she checked the resident's oxygen saturation and pulse, but did not check the resident's lung sounds. After the treatment was completed, LPN # 13 again checked the resident's oxygen saturation and pulse, but again failed to check the resident's lung sounds. The nebulizer medication dispenser was then placed in a plastic bag at the resident's bed side without being rinsed.</p> <p>3. A 01/2011 policy titled "Respiratory: Nebulizer Mist Therapy" was provided by the Director of Nursing on 11/17/11 at 10:55 a.m., and deemed as current. The policy indicated: "...Procedure...7. Assess lung fields and heart rate as applicable...16. Switch aerosol unit off when treatment is complete. 17. Assess lung fields and heart rate and document any changes. 18. Rinse excess mist and medication from nebulizer, t-piece, mouthpiece or mask. 19. Store dried nebulizer, t-piece, mouthpiece or mask in</p>		<p>care. The medication administration record of residents who receive nebulizer treatments have been updated to include pre and post assessment of heart rate and lung sounds. The tubing and cup was replaced with clean supplies for the affected residents.</p> <p>Licensed nursing staff will be educated on guidelines for the administration of nebulizers inclusive of completion of the pre and post assessment and the proper cleaning and storage of related supplies.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</p> <p>The Director of Care Delivery or designee will conduct random medication administration observations on each shift a minimum of twelve times per week to ensure nebulizer therapy and related documentation is provided per facility guidelines.</p> <p>How the corrective action(s)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0332 SS=E	<p>a separate labeled plastic bag...."</p> <p>3.1-47(a)(6)</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater. Based on observations, record reviews, and interview, the facility failed to ensure it was free of a medication error rate of 5% or greater for 4 of 41 opportunities during 4 of 11 nursing staff observed and for 4 of 14 residents observed during medication pass. The medication error rate was 9.75 %. (Resident #'s 73, 114, 99, and 85) (LPN #'s 2, 12, 22, and 3)</p> <p>Findings include:</p>	F0332	<p>will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #'s 114, 73 and 99 no longer resides at the facility.</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>1. On 11/15/11 at 11:43 a.m., during medication pass observation, Resident #114's insulin administration was observed. LPN #3 was observed to prepare and administer the 14 units of Humalog insulin in his left outer upper arm at 11:45 a.m.</p> <p>On 11/15/11 at 1:20 p.m., during an interview, Resident #114 indicated he had not had anything to eat since breakfast.</p> <p>On 11/15/11 at 1:25 p.m., Resident #114 received his room lunch meal tray and was preparing to eat.</p> <p>On 11/17/11 at 10:45 a.m. during an interview, LPN #3 indicated after receiving Humalog insulin one should eat within 15 to 30 minutes.</p> <p>Resident #114's record was reviewed on 11/16/11 at 2:55 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus Type II.</p> <p>The physician order, dated 10/04/11, was Humalog 100 units per milliliter vial inject subcutaneously (sub-q) per sliding scale before meals and at hour of sleep.</p> <p>The physician order, dated 10/04/11, was Humalog 100 units per milliliter vial inject 10 units sub-q 3 times daily before</p>		<p>Clinical record review was completed for resident #85. At the time of the surveyor observation, the resident was assessed with no negative outcome noted. Physician and family notified of incident and no new orders received from the physician.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>All residents that receive medications have the potential to be affected by the same deficient practice.</p> <p>Licensed staff will be educated on facility proper medication administration guidelines inclusive of timely administration of insulin and providing medication as per physician order.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>meals.</p> <p>2. On 11/15/11 at 11:40 a.m., Resident #73's Accucheck (to check a blood sugar with a blood sample) was observed. After completing the Accucheck, LPN #2 indicated the resident's blood sugar was 305 requiring insulin coverage. She also indicated she would wait closer to lunch before giving the insulin coverage.</p> <p>On 11/15/11 at 12:55 p.m., during medication pass observation, Resident's #73's insulin administration was observed. LPN #2 indicated the resident was to receive 8 units of Novolog insulin utilizing the Novolog Flex Pen. After 8 units was dialed up with the Novolog Flex pen, the insulin was observed given in the left lower abdomen at 12:55 p.m.</p> <p>On 11/15/11 at 1:20 p.m., the room lunch tray cart was observed to arrive on Resident #73's hallway as the passing of the lunch trays began.</p> <p>Resident #73's record was reviewed on 11/15/11 at 11:15 a.m. The resident's diagnoses included, but were not limited to, Diabetes Mellitus Type II.</p> <p>The physician's order, dated 11/04/11, was Novolog sliding scale with Accuchecks before meals and at hour of</p>		<p>practice does not recur:</p> <p>The Director of Care Delivery or designee will conduct random medication administration observations on each shift a minimum of twelve times per week to ensure proper technique and follow up is in place.</p> <p>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 into place:</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>sleep. The sliding scale included, but was not limited to, a blood sugar of 301 to 350 = 8 units of Novolog insulin.</p> <p>3. On 11/17/11 at 3:00 p.m., during an interview, DCD #1 indicated one medication information source available for the nurse's use was the Nursing 2009 Drug Handbook. This current source indicated the following:</p> <p>Novolog insulin should be given 5 to 10 minutes before the start of a meal. In the patient teaching information, one should teach the patient the importance of timing the dose to meals and adhering to meal plans;</p> <p>Humalog should be injected 15 minutes before or after a meal to control hyperglycemia.</p> <p>The "Nurse Practitioners' Prescribing Reference" for FALL 2011 was provided by the Director of Nursing on 11/21/11 at 9:40 a.m. This current information indicated Humalog given sub-q should be given 15 minutes before meal or immediately after a meal.</p> <p>4. On 11/15/11 at 4:00 p.m., medication pass was observed. LPN #22 was observed to prepare Resident #99's oral medications and obtain the Advair Diskus</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>(medication to aid respiratory function). Upon entering the resident's room, LPN #22 handed Resident #99 his Advair Diskus. Resident #99 was observed to turn the diskus to the present dose, place it into his mouth and inhale to complete the administration of this medication. He then handed the Advair diskus back to LPN #22 as he swished water in his mouth and swallowed it.</p> <p>Resident #99's record was reviewed on 11/16/11 at 2:45 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD).</p> <p>The physician's order, dated 9/19/11, was Advair 100-50 diskus inhale 1 puff by mouth 2 times daily with the diagnoses of COPD.</p> <p>The "Nursing 2011 Drug Handbook" indicated the following information:</p> <p>Advair: Patient teaching: After administration, have the patient rinse their mouth without swallowing to prevent oral candidiasis (yeast infection). Instruct on proper use of prescribed inhaler to provide effective treatment.</p> <p>5. The record for Resident # 85 was reviewed on 11/16/11 at 9:10 a.m.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>Current physician orders for November 2011 indicated an order for Reglan (treatment of nausea and vomiting) 10 milligrams four times daily at 8 a.m., 12 p.m., 4 p.m., and 8 p.m.,</p> <p>During a medication pass observation on 11/15/11 at 12:15 p.m., LPN # 12 omitted Reglan from the observed medication pass. At 1:40 p.m., during interview, the LPN # 12 indicated she had not given the resident his Reglan.</p> <p>3.1-48(c)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0356 SS=C	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observations and interview, the facility failed to ensure staffing was posted timely and was knowledgeable concerning the record keeping of the staffing information for 4 of 4 days observed during the annual survey. This deficiency had the potential to impact 149 of 149 residents currently residing in the</p>	F0356	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No residents identified in the</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>facility. (November 15, 16, 17, and 18, 2011)</p> <p>Findings include:</p> <p>On 11/15/11 at 9:30 a.m., on 11/16/11 at 7:50 a.m., on 11/17/11 at 10:15 a.m., and 11/18/11 at 8:00 a.m., the posted staffing was observed for 11/07/11.</p> <p>On 11/18/11 at 11:25 a.m., during an interview, LPN #42 indicated she would post the staffing information when she arrived at the facility around 10:00 a.m. and would change the information as needed. She indicated the posted staff information should be kept for 1 year. At this same time during an interview, the Director of Nursing indicated staff posting information was kept from survey to survey.</p> <p>3.1-13(a)</p>		<p>surveyor observation.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</p> <p>LPN # 42 and ADNS was inserviced on the guidelines for posting the staffing information and maintenance of staffing records for a minimum of 18 months.</p> <p>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 into place:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure residents with orders for mechanical soft	F0363	<p>The Administrative Director of Nursing Services or designee will observe daily staff postings a minimum of 3 times per week to ensure proper posting. Staffing Coordinator will maintain master copies of postings in the scheduling office for a minimum of 18 months.</p> <p>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 into place:</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p> <p>What correction actions(s) will be accomplished for those</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>diets were served all the food items menued for a mechanical soft diet, residents with orders for enhanced foods were served enhanced foods and residents with orders for sugar, salt and carbohydrate restrictions were not served these restricted items 5 of 18 residents reviewed for following menus in a sample of 24 (Residents #32, #57, #81, #106 and #141).</p> <p>Findings include:</p> <p>1.) During an interview on 11/15/11 at 11:45 a.m., Dietary Aide #33 indicated the enhanced food item being served for lunch was enhanced pudding.</p> <p>During an interview on 11/15/11 at 5:00 p.m., Cook #34 indicated the enhanced food item being served for supper was enhanced creamed soup.</p> <p>2.) Review of the current, 11/15/11, facility, supper menu, provided by the Administrator on 11/15/11 at 2:00 p.m., indicated the following:</p> <p>a.) Carbohydrate controlled diets: No sugar No potato chips or potato salad</p>		<p>residents found to have been affected by the deficient practice:</p> <p>Clinical record reviews were completed for resident #'s 32, 57, 81, 106 and 141. There were no further incidents related to the sited observation. Staff to ensure resident receives diet as ordered.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>A chart audit was completed to identify other residents who currently receive mechanical soft diet and enhanced foods. Residents were also identified who are currently on sugar, salt and/or carbohydrate restrictions.</p> <p>Dietary staff will be inserviced on following diet spreadsheets including the provision of enhanced food items, mechanically altered meal items, and restricted diets as per</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>b.) Mechanical soft diets: 1/2 cup potato salad</p> <p>3.) Resident #57's record was reviewed on 11/15/11 at 1:00 p.m.</p> <p>Resident #57's current diagnoses included, but were not limited to, Alzheimer's disease and hypothyroidism.</p> <p>Resident #57 had a current 10/11 physician's order for a Mechanical soft diet with enhanced foods.</p> <p>Resident #57 had a current 8/3/11 care plan problem regarding nutritional risk. An approach to this problem was to provided prescribed diet.</p> <p>During an 11/15/11, 12:50 p.m., lunch meal observation, Resident #57 was not served an enhanced food item with her meal, nor was any enhanced food item served during the remainder of the meal.</p> <p>During an 11/15/11, 5:30 p.m., supper observation, Resident #57 was not served any potatoes salad or a substitute for potatoes salad.</p> <p>4.) Resident #81's record was reviewed on 11/15/11 at 11:25 a.m.</p> <p>Resident #81's current diagnoses included,</p>		<p>physician order.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</p> <p>The Food Service Director, Registered Dietitian or designee will complete random breakfast, lunch and dinner tray audits a minimum of 3 days per week to validate that residents are receiving meals as ordered by the physician.</p> <p>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 into place:</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>but were not limited to, cerebral atrophy and depression.</p> <p>Resident #81 had a current 10/11 physician's order for a mechanical soft diet with enhanced foods.</p> <p>Resident #81 had a current,10/28/11 care plan problem/need regarding nutritional risk. An approach to this problem was to serve prescribed diets.</p> <p>During an 11/15/11, 12:50 p.m., lunch meal observation, Resident #81 did not receive enhanced pudding or any other enhanced item.</p> <p>During an 11/15/11, 5:30 p.m. supper observation, Resident #81 was not served a potato salad or a substitute for potato salad.</p> <p>During an 11/15/11, 5:40 p.m., interview, when questioned, Cook #32 indicated residents with mechanical soft diets were not served potato salad in error and she would correct the problem.</p> <p>5. On 11/15/11 at 1:00 p.m., Resident #141 was observed to receive her lunch tray. No pudding was included with her meal tray.</p> <p>On 11/15/11 at 5:45 p.m., Resident #141 was observed to receive her dinner tray.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>No creamed soup was included with her meal tray.</p> <p>Resident #141's record was reviewed on 11/15/11 at 4:30 p.m. The resident's diagnoses included, but were not limited to, dementia - Alzheimer's type, dehydration, and irritable bowel syndrome.</p> <p>The rewrite physician's orders, signed 9/09/11, included, but was not limited to, a mechanical soft diet with enhanced foods.</p> <p>6. The record for Resident # 106 was reviewed on 11/15/11 at 11 a.m.</p> <p>Physician orders for November 2011 indicated an order for a no added salt diet and carbohydrate control diet.</p> <p>On 11/15/11 at 5:47 p.m., the resident was in her room with her meal tray. Her tray included 2 packets of salt and 2 packets of sugar. At that time, RN # 28 observed the tray and removed the salt and sugar packets. She informed dietary of the error.</p> <p>7. The record for Resident # 32 was reviewed on 11/17/11 at 8:30 a.m.</p> <p>Current physician orders for November 2011 indicated the resident was on a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
F0372 SS=C	<p>carbohydrate controlled diet.</p> <p>On 11/15/11 at 6:20 p.m., Resident # 32's tray was observed. She had potato salad on the tray. At that time LPN # 11 was informed and the potato salad was removed from the tray. She indicated the resident was not to have the potato salad.</p> <p>8. A "One-to-one inservice record" was provided by the Registered Dietician on 11/21/11 at 2:35 p.m. The form indicated: "...Following each diet's spreadsheet is critical not only to the patients' nutritional needs but could have a life or death consequence when not adhered to...." This inservice note indicated the training was provided on 11/21/11 to the dietary staff in response to survey concerns.</p> <p>3.1-20(i)(4)</p> <p>The facility must dispose of garbage and refuse properly. Based on observations and interviews, the facility failed to ensure refuse was contained in covered dumpsters for 4 of 4 days observed. This deficiency had the potential to impact 149 of 149 resident residing in the facility. (November 15, 16, 17, and 21, 2001)</p>	F0372	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No residents identified in the</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Findings include:</p> <ol style="list-style-type: none"> On 11/15/11 at 9:40 a.m., at 1:30 p.m., and at 3:30 p.m., one of the 2 dumpsters was observed not fully closed with a cardboard box protruding from the dumpster. On 11/15/11 at 5:35 p.m., the same dumpster was observed with the same cardboard box visible. The second dumpster was observed with the lid off and white trash bags piled up. On 11/16/11 at 7:55 a.m. and at 10:05 a.m., the second dumpster was observed with an open lid with no trash presently visible. Also, in the back of this dumpster, the lid was open with no trash/cardboard observed. On 11/16/11 at 3:30 p.m., the back of the second dumpster was observed opened with boxes visible. On 11/16/11 at 4:42 p.m., one dumpster was observed with no lid on with trash visible. Also, in the second dumpster the back part of the dumpster remained open with cardboard protruding out of the opening. On 11/17/11 at 10:40 a.m., the first dumpster was observed with the no lid 		<p>surveyor observation.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The dumpsters were replaced with equipment that will not allow the lids to fall open backwards and remain open when placed back in place by the waste removal company.</p> <p>Staff will be inserviced on the importance of keeping the dumpster area lids closed and ensuring loose debris around the dumpster is properly disposed of.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>and a box sticking out of the dumpster. The second dumpster was also observed open in the back of this dumpster with no trash/cardboard visible at this time.</p> <p>7. On 11/17/11 at 1:50 p.m., at the end of the environmental tour and during an interview, the Maintenance Director indicated the dumpsters were emptied 6 days a week. He indicated the back of the second dumpster was for cardboard recycling and had a sliding door, which should be closed. At this same time as 1 of the 2 dumpster lids was opened and piled up with white trash bags. The Maintenance Director also indicated at times the dumpster company would not make sure the lid is closed before returning it to the area, which required him to move the dumpster back out of the area to close the lid.</p> <p>8. On 11/21/11 at 8:35 a.m., the dumpster area was observed with debris, for example, loose white papers, around the dumpsters.</p> <p>3.1-21(i)(5)</p>		<p>The Maintenance Director or designee will randomly monitor the dumpster area a minimum of 5 days per week to ensure proper disposal of trash and the absence of loose debris around the dumpster.</p> <p>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 into place:</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
--------------------	--	---------------	---	----------------------

F0441 SS=E	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, record review, and interviews, the facility failed to ensure effective infection control practices were</p>	F0441	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	12/21/2011
---------------	--	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011			
(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			
	<p>implemented related to equipment and linen handling and handwashing/glove use during personal care, dressing change, medication pass, Accuchecks and respiratory treatments. These practices affected 13 of 28 residents observed for infection control (Resident #'s 137, 22, 85, 94, 73, 87, 127, 77, 114, 36, 2, 71, and 65) and involved 13 of 24 nursing staff observed for infection control practices. (CNA #'s 7, 17, 18, and 29; LPN #'s 2, 3, 4, 6, 9, 12, 23, and 30; DCD #1; RN #4).</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 11/15/11 from 9:45 a.m. to 10:55 a.m., during initial tour with the Director of Care Delivery (DCD) #1, Resident #137 was observed in his bed with his eyes closed. The resident's uncovered nebulizer mask was setting on top of the oxygen concentrator with no treatment or oxygen being used. During this same initial tour with DCD #1, Resident #22 was observed in her bed with her right bootie observed off. After it was reapplied by DCD #1, no handwashing/handgel use was observed as DCD #1 left the room, and the initial tour was completed. On 11/15/11 from 11:30 a.m. to 11:40 a.m., Resident #73 Accucheck (to check a blood sugar with a blood sample) was 		<p>practice? Clinical record review was completed for resident #137. Nebulizer mask was replaced with clean supplies. Clinical record review was completed for resident #22. The resident had no noted negative outcomes from the observed deficient practices. Resident #'s 73 and 87 no longer reside at the facility. Clinical record review was completed for resident #127. The resident had no noted negative outcomes from the observed deficient practices. Resident # 114 no longer resides at the facility. Clinical record review was completed for resident #36. The resident had no noted negative outcomes from the observed deficient practice. Clinical record review was completed for resident #2. The resident had no noted negative outcomes from the observed deficient practices. Clinical record review was completed for resident #71. The resident had no noted negative outcomes from the observed deficient practices. Clinical record review was completed for resident #85. Nebulizer tubing was replaced with clean supplies. The resident had no noted negative outcomes from the observed deficient practices. Clinical record review was completed for resident #94. The resident had no noted negative outcome from the observed deficient practice. Clinical record review was completed for resident #77.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>observed. After preparing her supplies, LPN #2 handwashed for less than 10 seconds and donned a pair of gloves. After completing the Accucheck, she disinfected the glucometer, removed her gloves, and returned to her medication cart. When the resident's bed alarm was found to be disconnected, she returned to the room, corrected the disconnected bed alarm, and left the room. No handwashing/handgel use was observed as she returned her Accucheck supplies to the medication cart.</p> <p>3. On 11/15/11 from 11:45 a.m. to 11:50 a.m., Resident #87's Accucheck was observed. After LPN #3 completed the Accucheck, she was observed to handwash for less than 10 seconds. Then she proceeded to change the resident's oxygen tubing.</p> <p>4. On 11/15/11 from 11:57 a.m. to 12:25 p.m., Resident #127's Accucheck was observed. In preparation, LPN #4 was observed to enter the resident's room, picked up his bed controller from the floor, returned to her medication cart, collected her Accucheck supplies, and returned to his room. After she handwashed for less than 10 seconds, she donned a pair of gloves and completed the Accucheck. When LPN #4 found the sharp's container in the resident's room</p>		<p>Nebulizer machine was cleaned and tubing was replaced with clean supplies. The resident was provided with an appropriate equipment storage container. The resident had no noted negative outcome from the observed deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the deficient practice. Nursing staff will be educated on guidelines for proper handwashing. Licensed staff will be educated on nebulizer therapy to include storage of tubing and equipment. Certified nursing staff will be educated on the guidelines for proper perineal and catheter care. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: Director of Care Delivery or designee will observe handwashing on at least 10 staff per week for proper techniques per facility guideline. Director of Care Delivery or designee will observe a minimum of 10 times per week for proper perineal and catheter care to prevent the spread of infection. The Director of Care Delivery or designee will conduct random medication administration observations on all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011			
(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			
	<p>full, she removed her gloves, donned another pair of gloves and disinfected the glucometer, which was then set directly on the resident's bedside table with no barrier used. She then handwashed for less than 5 seconds and then she left the room to obtain a new sharp's container for the resident's room.</p> <p>5. On 11/15/11 during medication pass observations, the following was observed:</p> <p>At 11:43 a.m., LPN #3 with gloved hands was observed to administer Resident #114's insulin injection in his left outer upper arm. After removing her gloves, she was observed to handwash for 10 seconds and then, returned to her medication cart to continue her medication pass.</p> <p>At 12:10 p.m., RN #4 was observed to prepare and administer Resident #36's oral crushed medications. She then was observed to handwash for less than 10 seconds as she returned to her medication cart to continue her medication pass.</p> <p>At 12:32 p.m., RN #4 was observed to prepare Resident #127's insulin coverage. Upon entering the resident's room, RN #4 was observed to handwash for less than 5 seconds, donned a pair of gloves, administered the medication in the</p>		<p>shifts a minimum of twelve times per week to monitor for proper hand washing, storage of nebulizer tubing, and equipment. 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 into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**Will the Director of Care Delivery observe hand washing techniques on 10 staff members weekly on all shifts? Will the Director of Care Delivery observe proper care and cleaning of anchored catheters 10 times weekly on all shifts?The Director of Care Delivery or designee will observe hand washing techniques on at least 10 staff per week on all shifts for proper techniques per facility guideline. The Director of Care Delivery or designee will observe proper care and cleaning of anchored catheters a minimum of 10 times per week on all shifts.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>resident's upper outer right arms, and removed her gloves. She again was observed to handwash for less than 5 seconds.</p> <p>At 12:50 p.m., LPN #2 was observed to handwash for 10 seconds, prepare Resident #73's Novolog Flex pen, and administered the insulin subcutaneously in the resident's left lower abdomen. She again was observed to handwash for less than 10 seconds to complete the task. At this same time during an interview, LPN #2 indicated one should handwash for 20 seconds. She also indicated one should handwash between residents, before and after medication administration, and when entering or leaving a resident's room.</p> <p>At 3:40 p.m., after LPN #23 poured Resident #2's oral medications in a medicine cup, she indicated the resident took his medications crushed. Next, she was observed to open the plastic sleeve for crushing the medications by placing her finger inside this plastic sleeve. The medications were then crushed in this same sleeve and administered to the resident with pudding.</p> <p>At 6:30 p.m., LPN #6 was observed to prepare and administer Resident #71's medications. No handwashing/handgel use was observed as LPN #6 entered</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
	<p>Resident #65's room and then wheeled him out to the nurse's station.</p> <p>6. On 11/16/11 from 1:50 p.m. to 2:20 p.m., Resident #22's personal care was observed. After CNA #7 donned a pair of gloves and prepared her supplies, she indicated the resident's peri-area was wet. At this same time during an interview, CNA #7 indicated the resident's Foley catheter was not leaking. After the resident was turned, no dressing was observed on her coccyx open area. The Chux (disposable underpad) under the resident was observed with a large dinner plate sized wet area. As CNA #7 cleansed the rectal area, the resident had been incontinent of a small amount of soft, brown bowel movement (BM). After wiping the BM off with a washcloth, she placed the washcloth on the floor. After completing the resident's care of the rectal area, CNA #7 with the same gloves picked up the washcloth and bagged it and covered up the resident. Next, she used a paper towel to turn the water on and placed this same paper towel on the side of the sink. After removing three more paper towels from the paper towel dispenser and placing these same paper towels also on the side of the sink, she was observed to handwash and dry her hands with the same paper towels retrieved from the side of the sink. After</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>telling the nurse about the lack of a dressing, CNA #7 returned to the room and indicated she needed to complete the resident's care. With gloved hands she was observed to cleanse each side of the resident's thighs several times with no cleansing of the vulva or Foley catheter tubing. After turning the resident, she then cleansed the rectal area to complete her care. With the same gloved hands, she repositioned the resident in the bed and removed her gloves. She then removed a paper towel from the dispenser, turned on the water with the same towel, and set the towel on the side of the sink. After dispensing more paper towels, she handwashed and used the same paper towels on the side of the sink to dry her hands. She then took the bagged trash, bagged the towel on the floor, and left the room. After retrieving assistance, CNA #7 and CNA #8 were observed to pull the resident up in her bed. No handwashing/handgel use was observed as the CNAs' left the room and continued down the hall.</p> <p>7. On 11/16/11 from 4:15 p.m. to 4:40 p.m., Resident #22's coccyx dressing application was observed. After preparing her supplies, DCD #1 was observed to handwash for less than 10 seconds. After donning a pair of gloves, DCD #1 completed the dressing change. Then,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>DCD #1 removed her gloves, handwashed for less than 10 seconds, and donned a new pair of gloves. With LPN #9's assistance, Resident #22 was repositioned and turned on her right side. After the resident indicated she was comfortable, DCD #1 was observed to remove her gloves and handwashed for 12 seconds. Next, LPN #9 was observed to remove her gloves and handwashed for less than 10 seconds.</p> <p>8. During a medication pass observation of Resident #85 with LPN # 12 on 11/15/11 at 12:15 p.m., the LPN set up the resident's nebulizer treatment. After she hooked up the tubing to the machine, she turned the machine on. The tubing "popped" off the machine and landed on the floor. She then picked up the tubing, reconnected it to the machine and the resident continued the nebulizer treatment. She then donned one glove and used a towel to wipe white foamy secretions from the resident's tracheotomy site. She then removed the glove and washed her hands for 7 seconds. She turned off the nebulizer machine, donned gloves, unhooked the tubing from the resident's tracheotomy mask and bagged the nebulizer tubing and medicine cup. She then placed the resident into the hallway.</p> <p>9. During a personal care observation on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>11/15/11 at 3:40 p.m., of Resident # 85 with CNA # 17 and # 18, before the resident was transferred into bed, CNA # 17 placed the resident's anchored catheter tubing and drainage bag onto the resident's lap. The tubing and bag had urine in them. The tubing and drainage bag were touching the resident gastrostomy tube and his jejunostomy tube. When the care was completed, CNA # 18 removed her gloves and washed her hands for less than 10 seconds, donned gloves and brushed the resident's teeth.</p> <p>10. During a personal care observation 11/16/11 at 10:10 a.m., of Resident # 94 with CNA # 29. CNA # 29 assisted in providing perineal care to the resident, applied the brief and covered up the resident with gloved hands. She then removed her gloves, washed her hands for 6 seconds and gave the resident a drink of water.</p> <p>11. On 11/16/11 at 10:20 a.m., Resident # 77 was in her room. Her nebulizer machine and nebulizer tubing was on the floor in her room. At that time, LPN # 30 was informed and she indicated the resident sometimes placed her machine on the floor.</p> <p>12. A 12/2009 policy title "Hand</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>Hygiene" was provided by the Director of Nursing on 11/17/11 at 10:55 a.m., and deemed as current. The policy indicated: "...Purpose: To decrease spread of infection...When to wash hands or use an alcohol-based hand rub: Before applying and after removing gloves After having direct contact with patient's intact skin...After contact with body fluids or excretions...Moving form a contaminated body site to a clean body site during patient care After contact with inanimate objects...Procedure...Rub hands vigorously for at least 15 seconds, covering all surfaces of the hands and fingers...Turn off water with paper towel..."</p> <p>A 12/2009 policy title "Incontinence Care" was provided by the Director of Nursing on 11/17/11 at 10:55 a.m., and deemed as current. The policy indicated: "...Cleanse peri area and buttocks with a cleansing agent wiping from front of perineum toward rectum. Turn patient side to side to cleanse the entire affected area, as needed...Dry peri-area and buttocks from front to back..."</p> <p>3.1-18(l) 3.1-19(g)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011
---	--

(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
F0456 SS=D	<p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure wheelchairs were in good repair related to wheelchair brakes, arm and chair pads, and the back of a wheelchair for 1 of 4 residents (Resident #141) observed utilizing their wheelchair in a sample of 24 and for 1 of 1 supplemental resident (Resident #104) in a sample of 15.</p> <p>Findings include:</p> <p>1. On 11/15/11 from 1:44 p.m. to 1:50 p.m., Resident #141's personal care was observed. As CNA #5 prepared to transfer the resident from her wheelchair (w/c) to her bed, he indicated the resident's w/c brakes were "not holding." As the resident was transferred to her bed, her w/c was observed to move as the resident was being transferred. Also, the right arm of the w/c had no padding on it exposing a black surface with a middle screw visible. Her w/c pad was observed with a 1/2 inch torn area exposing the</p>	F0456	<p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The wheelchairs for resident #'s 141 and 104 were replaced.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>A chart audit was completed to identify other residents who use wheelchairs.</p> <p>Wheelchairs will be inspected to ensure proper functionality.</p>	12/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>inside padding.</p> <p>2. On 11/17/11 at 3:38 p.m. during an interview, Resident #104 indicated her wheelchair (w/c) was broken and no longer would recline to give her relief from sitting up in the w/c. At this same time, she also indicated she had reported the w/c to the Maintenance Director 2 months ago with no results.</p> <p>On 11/18/11 at 1:35 p.m. during an interview, information was requested related to Resident #104's w/c.</p> <p>3. On 11/18/11 at 12:50 p.m. during an interview, the Director of Caring Delivery #1 indicated if their was a problem with a wheelchair, a work form should be filled out. If the equipment needed immediate attention, one should still fill out the work form and also contact maintenance. At this same time, DCD #1 was informed of Resident #141's wheelchair brakes and missing arm pad, and she indicated Resident #104 was to be reevaluated by Occupational Therapy.</p> <p>On 11/21/11 at 3:40 p.m. during an interview, the Director of Nursing provided the following: A work order form, dated 9/29/11, for Resident #104 indicating the left handle cord was broken on her w/c. He indicated</p>		<p>Staff will be inserviced on proper completion of work orders to maintain functionality of wheelchairs.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</p> <p>The Maintenance Diretor or designee will randomly monitor the functionality of wheelchairs a minimum of 5 days per week to ensure proper functioning</p> <p>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 into place:</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
F0465 SS=D	<p>he had talked to therapy concerning not having the w/c part available to fix her w/c. A physician order, dated 11/21/11, was to have Occupational Therapy to evaluate Resident #104 for her w/c positioning and mobility.</p> <p>3.1-19(bb)</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations, record review, and interviews, the facility failed to ensure service areas were sanitary and in good repair related to the condition of the floors and walls for 2 of 2 clean utility rooms, for 2 of 2 soiled utility rooms, for 1 of 2 medication rooms, for 1 of 2 nurse's station, for 2 of 2 closet/storage rooms and for 1 of 1 ice machine room observed. (Family Tree's medication room, Family Tree's nurse's station and soiled utility room, 400 hall's clean and soiled utility rooms and janitor's closet, 500 hall storage room, Medicare clean utility room, and the ice machine room)</p> <p>Findings include:</p>	F0465	<p>determine need for further monitoring and/or education per the QA&A process.</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: No residents identified in the surveyor observation. The linen barrel was transported to laundry. The gap around the hopper was repaired. The Family Tree medication room was cleaned. Medications were destroyed or returned to pharmacy as appropriate. A purchase order has been completed and approved at the corporate level for the tile to be repaired or replaced on the Family Tree unit including the circular area surrounding the nurses station. The 400 hall janitor's closet was cleaned, the</p>	12/21/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>1. On 11/15/11 at 12:25 p.m., LPN #4 was observed to enter the soiled utility room located at the Family Tree's nurse's station. The linen barrel was observed with the lid off. This same barrel was full of bagged linen with 1 bag setting on the floor. A gap was observed around the 3 pipes at the hopper area.</p> <p>2. On 11/15/11 from 12:25 p.m. to 12:30 p.m., the Family Tree medication room was observed with LPN #4 present. The floor was observed with several loose black plastic ties and loose, gray dust along the wall with dried spilled brown to black spots observed scattered on the floor. The sink was observed full of bottles and boxes of medications. At this same time during an interview, LPN #4 indicated the medications were to be destroyed due to residents' discharges.</p> <p>On 11/15/11 at 6:25 p.m., the Family Tree medication room was again observed with a sink full of bottles and boxes of medications. At this same time during an interview, the DCD #1 indicated the medications were to be sent back and/or destroyed, which was to be done within 7 days. She also did not identify a problem with the sink not being available for use. The floor was observed as before in appearance and with the same black</p>		<p>cove base was repaired, and the electrical outlet cover was replaced. The Family Tree clean utility room was cleaned. The Family Tree soiled utility room was cleaned. The soiled linen was transported to laundry. The Family Tree medication room was cleaned. The storage room on the 500 hall was cleaned. The ice machine room was cleaned. A purchase order has been completed and approved at the corporate level for the tile to be repaired or replaced on the Family Tree unit including entry to the ice machine room and the tiles located around the ice machine. The Medicare clean utility room was cleaned including the counter top and faucet sink. The baseboards were cleaned and the chipped area was repainted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. Staff will be inserviced on maintaining acceptable levels of cleanliness, proper functionality in the service areas, and completion of work orders. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur: The Environmental Services Director,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>plastic connectors on the floor.</p> <p>3. On 11/16/11 at 3:00 p.m., the circular area surrounding the nurse's station was observed with dark brown to black substance in the pencil thin gaps in the majority of the 12 inch floor tiles. Also, the floor area inside the nurse's station was observed dull and with scattered irregular shaped, black areas of various sizes, which range from a nickel to a half dollar sizes.</p> <p>4. On 11/16/11 from 12:35 p.m. to 1:50 p.m., the environmental tour was completed with the Maintenance Director and the Director of EVS (Environmental Services). The following was observed:</p> <p>Upon entering the 400 hallway, the following was observed:</p> <p>In the janitor closet containing the floor scrubbers, the floor was observed with various areas of black and brown spots throughout; on 1/2 of the southwest wall and along the south wall, the cove base was missing; an electrical outlet cover was missing with a machine plugged into this same outlet. At this same time during an interview, the Director of EVS indicated the floor scrubber was presently plugged in to recharge the machine.</p>		<p>Maintenance Director or designee will randomly monitor the cleanliness and proper functionality of the service areas a minimum of 3 days per week.</p> <p>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 into place: Audit findings will be presented to QA&A committee weekly for 4 weeks and then as determined by the QA&A committee for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. **Addendum Response**For each purchase order completed and approved by corporate, please indicate the expected date the repair or replacement will begin, and the expected/approximate date of completion. FYI: The survey team may review any approved contractor quotes and/or approved work orders for work that is not completed at the time of the revisit.</p> <p>A purchase order has been completed and approved at the corporate level for the tile to be repaired or replaced on the Family Tree unit including the circular area surrounding the nurses station. This work will start on or about 2/13/2012 and will be completed no later than 3/8/2012. Approved quotes</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>At the nurse's station, the clean utility room was observed with scattered debris and gray dust on the floor. At this same time during an interview, the Director of EVS indicated housekeeping would remove the trash from the room, but no day to day cleaning was done.</p> <p>At the nurse's station, the soiled utility room was observed with 1 full barrel of bagged linen with no lid on, and 1/2 full second barrel of bagged trash with no lid on. One linen bag was also observed on the floor. At this same time during an interview, the Director of EVS indicated laundry would make rounds 2 times a day to check on the linen barrels, and the CNA's were to take the barrels when full and/or at the end of their shift.</p> <p>The medication room at the Family Tree nurse's station was observed with the same black plastic tiles and gray dust present on the floor. At this same time during an interview, the Director of EVS indicated the nurse's were responsible for cleaning the medication room.</p> <p>The nurse's station's floor around the outside and on the inside was observed as before on 11/16/11 at 3:00 p.m.</p> <p>In the 500 hall in the storage area, paper debris and loose gray dust was observed</p>		<p>and/or work orders will be made available to the survey team in the event the work is not completed at the time of the revisit.</p> <p>A purchase order has been completed and approved at the corporate level for the tile to be repaired or replaced on the Family Tree unit ice machine room. This work was completed 12/21/2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>throughout the area. At this same time, the Ancillary Manager indicated he would periodically sweep the area.</p> <p>In the ice machine room, gray dust and debris, including plastic cup caps, straws, and loose paper, were observed throughout the room. At this same time during an interview, the Director of EVS indicated the room needed to be swept. At the doorway to the dining room area, 1/2 inch width and 6 inches long at the top of a 12 inch floor tile was missing. The floor tiles around the ice machine were observed with 1/8 inch gaps with a dark brown to black accumulated substance in these gaps. The floor was observed discolored and dull with scattered areas of gapping between some of the 12 inch floor tiles.</p> <p>5. During the environmental tour on 11/16/11 at 9 a.m., with the Maintenance Director and the Environmental Services Director the following was observed. The Medicare clean utility room: The counter top around the sink was stained dark brown and the faucet and sink had an accumulation of hard water build-up. The baseboards were splattered and there was an approximate 3 foot area of chipped paint on the wall at the entrance.</p> <p>The "Laundry Services" policy was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011		
(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	
	<p>provided by the Director of Nursing on 11/21/11 at 9:40 a.m. This current policy indicated the following:</p> <p>"Soiled linen has been shown to be a source of large numbers of pathogenic organisms....Techniques minimizing potential nosocomial and occupational risks associated with soiled linen handling include: ...* empty linen containers when three fourths full preventing overflow * secure lids to linen containers prior to transport...."</p> <p>3.1-19(f)</p>				