

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  02/07/2013
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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011
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F0000	<p>This visit was for the Investigation of Complaints IN00123416 and IN00123792.</p> <p>Complaint IN00123416, Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00123792, Substantiated. Federal/State deficiencies related to the allegations are cited at F241, F323, and F325.</p> <p>Survey dates: February 6, 7, 2013</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Survey team: Ginger McNamee, RN, TC Karen Lewis, RN, TC Betty Retherford, RN Lynn Mackey, RN</p> <p>Census bed type: SNF/NF: 32 SNF: 126 Total: 158</p> <p>Census payor type: Medicare: 19 Medicaid: 108 Other: 31</p>	F0000	<p>February 22, 2013 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:</p> <p>Please note our Plan of Correction and allegation of compliance for the Recertification and State Licensure Survey completed on February 7, 2013. We respectfully request a desk review. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated. 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.</p> <p>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.

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	<p><b>Total: 158</b></p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>				

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on record review and interview, the facility failed to ensure a resident with a declining health condition was assessed and monitored in her ability to use her call light and summon staff for assistance for 1 of 1 resident reviewed with a physically incapacitating health condition in a sample of 8. (Resident #G)</p> <p>Findings include:</p> <p>The clinical record for Resident #G was reviewed on 2/6/13 at 11:40 a.m.</p> <p>Diagnoses for Resident #G included, but were not limited to, Guillian Barre Syndrome, generalized debility, hypertension, and depression.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 12/14/12, indicated Resident #G was cognitively intact with a Brief Interview for Mental Status score of 15/15. The assessment also indicated the</p>	F0241	<p><b>Tag F 241 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident (G) was reassessed and provided with a "breathcall" blow alert call light trigger system. Resident was educated on the use of the new call light and medical record was updated to reflect the changes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; Residents with physically incapacitating declining health conditions have the potential to be affected by the deficient practice. They have been identified and reassessed for the ability to appropriately utilize call lights. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur; Licensed Nurses and C.N.A.'s have been provided education on the call light response guidelines. See Attachment A. How the</b></p>	03/09/2013			

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	<p>resident required extensive assistance of one, two or more persons for all activities of daily living.</p> <p>During an interview on 2/7/13 at 8:40 a.m. with Resident #G, she indicated she could not use her call light due to the recent decline in her health condition and was now unable to use her hands. She indicated she yelled for staff when she needed assistance. She also voiced concerns of not being able to make herself heard as it was getting more difficult for her to yell loudly.</p> <p>During an observation on 2/7/13 at 8:40 a.m., Resident #G's room was located next to the last room on the left side of Hall 200 of the Family Tree Unit, approximately 80 feet from the nurses station.</p> <p>The "Care Plan Kardex Report" for the Certified Nursing Assistants providing care to Resident #G, provided by the Director of Nursing on 2/6/13 at 11:30 a.m., lacked any information related to the resident being unable to use her call light to summon staff assistance.</p> <p>During an interview on 2/7/13 at 12:45 p.m. with LPN #1, she indicated until recently Resident #G was able to</p>		<p><b>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;</b> The Director of Care Delivery or designee will conduct daily monitoring of residents call lights which will include but is not limited to the residents ability to utilize the call light and timely response by staff. See Attachment B. Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process. <b>By what date the systemic changes will be completed?</b> March 9, 2013</p>		

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	<p>use her call light. LPN #1 was unable to give a specific time frame for Resident #G's decline in being able to use her call light. LPN #1 indicated Resident #G had been on 1 hour checks previously due to the resident yelling out. LPN #1 did not indicate any reason for the increase in the resident yelling out. LPN #1 indicated any of the nursing staff could update the "Care Plan Kardex Report."</p> <p>Review of a current policy titled "CALL LIGHT/ BELL RESPONSE" provided by RN # 2 indicated,</p> <p>"Purpose: To provide an audio and visual system to alert staff when assistance is needed. Guideline: Provide adaptive call light equipment to patients who cannot use standard call light devices."</p> <p>This Federal tag relates to Complaint IN00123792.</p> <p>3.1-3(t)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. Based on record review and interview, the facility failed to ensure a mechanical lift was used when required for transferring 1 of 4 residents reviewed who needed a mechanical lift for transfers in a sample of (Resident # B)</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 2/6/13 at 11:45 a.m. The resident's diagnoses included, but were not limited to, lung cancer with brain metastasis, generalized weakness, type II diabetes mellitus, and altered mental status.</p> <p>Review of the 2/4/13, 4:00 p.m., progress note indicated a CNA was attempting to transfer the resident from his bed to his wheelchair. During the transfer, the resident's legs gave out and he was lowered to the floor.</p> <p>Review of the 2/4/13 "Incident Report" indicated the CNA was</p>	F0323	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Resident B was reassessed and chart includes comprehensive assessment and interventions to accommodate safe transfers with the use of a mechanical lift.</p> <p>C.N.A. involved in incident received disciplinary action for failure to follow a work rule. C.N.A. was reeducated on the Fall Practice Guidelines which includes following a plan of care and interventions.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>Residents having the potential to be affected by the deficient practice have been identified and chart reviewed to ensure appropriate interventions are in place and available for staff to visualize prior to providing care to the residents.</p>	03/09/2013

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	<p>attempting to transfer the resident from bed to wheelchair and the residents legs were weak and gave out. The resident was lowered to the floor.</p> <p>The resident had a 1/29/13 Fall Assessment indicating he was a fall risk.</p> <p>The resident had a care plan problem of "At risk for falls due to weakness." This problem was initiated on 1/3/13. The interventions for this problem were updated on 1/22/13 and the use of a Hoyer Lift for transfers was added.</p> <p>The "Care Plan Kardex Report" for Resident #B was provided on 2/6/13 at 11:30 a.m., by the Director of Nursing. The Director of Nursing indicated the Kardex is used as a tool for the CNA's to know know the type of care the residents need. The Kardex for Resident #B indicated he was to be transferred with a mechanical lift.</p> <p>During an interview with Physical Therapist #4 on 2/6/13 at 3:00 p.m., he indicated the resident had been assessed on 1/4/13 and on 1/31/13. He indicated the resident had experienced a decline in his condition</p>		<p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>Licensed Nurses and C.N.A.'s have been provided education on the Mechanical Lift Guidelines. See attachment C.</p> <p><b>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;</b></p> <p>The Director of Care Delivery or designee will conduct Mechanical Lift Transfer observations daily, including staff on days, evenings and nights, to ensure staff are following interventions for safe transfer of residents that require a mechanical lift. See attachment D.</p> <p>Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process.</p> <p><b>By what date the systemic changes will be completed?</b> March 9, 2013</p>		

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	<p>between the two assessments. He indicated he had notified the facility of the change and he had recommended the Hoyer lift be used for the resident's transfers.</p> <p>During an interview on 2/7/13 at 10:14 a.m., the Administrator indicated the CNA had not used a Hoyer lift during the transfer of the resident.</p> <p>During an interview with the Director of Nursing on 2/7/13 at 11:30 a.m., she indicated the CNA had been disciplined for not using the Hoyer lift during the transfer.</p> <p>Review of a current policy, titled "FALLS PRACTICE GUIDE," provided by the Director of Nursing on 2/7/13 at 10:58 a.m., indicated,</p> <p>"Purpose: To describe the process steps for identification of patient falls risk factors and interventions and systems that may be used to manage falls...."</p> <p>It also indicated that the interdisciplinary team designs the patients care plan to focus on all of the patients issues including those associated with the fall prevention and fall risk management. On the basis of the information obtained and</p>				

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	<p>analysis performed in the assessment and planning phases, the next step was to implement an organized approach for the management of the patient's fall or fall risk factors, and the staff would be educated on the updates.</p> <p>This Federal tag relates to Complaint IN00123792.</p> <p>3.1-45 (a)(2)</p>				

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure interventions to prevent weight loss were initiated and/or monitored to ensure weight loss was not preventable for 1 of 4 residents reviewed for weight loss in a sample of 8. [Resident #B]</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 2/6/13 at 11:45 a.m. The resident's diagnoses included, but were not limited to, lung cancer with brain metastasis, generalized weakness, type II diabetes mellitus, and altered mental status.</p> <p>The resident had a care plan problem, initiated on 1/4/13, for a risk of nutritional status and weight loss as evidenced by cancer, type II diabetes mellitus, history of</p>	F0325	<p><b>Tag F 325 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B was reassessed. Chart review completed including comprehensive assessment and interventions to maintain acceptable parameters of nutritional status, such as body weight and protein levels. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; Residents having the potential to be affected by the deficient practice have been identified. Chart reviews have been completed to ensure appropriate interventions are in place to maintain acceptable parameters of nutritional status, such as body weight and protein levels. What measures will be put into place or what systemic</b></p>	03/09/2013	

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	<p>chemotherapy and radiation treatments, and edentulous and prefers not to wear dentures. Some interventions for this problem included, but were not limited to, ..." honor food preferences, report signs or symptoms of diet and/or texture intolerance, snacks per patient preference...."</p> <p>The resident had signed physician's orders dated 2/3/13. The orders indicated the resident received a carbohydrate controlled, regular texture thin liquid diet.</p> <p>Review of the resident's weights indicated the following weights were obtained using the lift scale: 195.2 pounds on 1/2/13 186.6 pounds on 1/9/13 182.8 pounds on 2/1/13.</p> <p>Review of the 1/17/13, 11:17 a.m., Nutrition/Weight progress note indicated the resident had a 19 pound/9.5 % weight loss within the past month and 1 can of Ensure would be recommended at 10:00 a.m. everyday.</p> <p>During an interview with the Registered Dietician on 2/7/13 at 8:30 a.m., she indicated the resident did not wear dentures and he did not</p>		<p><b>changes will be made to ensure that the same deficient practice does not recur;</b> Licensed Nurses have been provided education on monitoring consumption and documentation of resident nutritional status for residents at risk for weight loss. See attachment E. <b>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;</b> The Director of Care Deliver or designee will conduct observations and documentation weekly on residents that are at risk for weight loss and receive nutritional supplements. Documentation will include review of interventions with MD and family, resident's tolerance of supplements and meals and any further need for interventions. See attachment F. Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process. <b>By what date the systemic changes will be completed?</b> March 9, 2013</p>		

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	<p>want an altered diet. She indicated the resident was offered a snack at 2:00 p.m. and 7:00 p.m. She indicated the snacks were rotated between peanut butter crackers, pudding, and yogurt. She indicated she did not monitor if the snacks and Ensure were consumed. She indicated the resident's condition was declining and that was the reason for the weight loss. She indicated the resident was not offered any alternate food choices.</p> <p>Review of the task manager lacked any indication of snacks being given at 2:00 p.m., and there was no record of the amount of the 7:00 p.m. snack consumed.</p> <p>During an interview with LPN #1 on 2/7/13 at 10:30 a.m., she indicated the Ensure was documented on the computer as accepted or refused. She indicated the amount consumed was not documented.</p> <p>This Federal tag relates to Complaint IN00123792.</p> <p>3.1-46(a)(1)</p>				