STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155005		03/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	1345 N MADISON AVE ANDERSON, IN 46011

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 7, 8, 9, 10, 11, 14, 2016 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census bed type: SNF: 10 SNF/NF: 106 Total: 116 Census payor type: Medicare: 3 Medicaid: 84 Other: 29 Total: 116 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.-3.1. QR completed on March 16, 2016 by 11474.	F 0000	**The facility would like to request a desk review for the alleged compliance for follow up from this annual survey Preparation and execution of this plan of correction does notconstitute an admission of or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared andexecuted solely because Federal and State Law require it. Compliance has been and will be achieved nolater than the last completion date identified in the POC. Compliance will be maintained as provided inthe Plan of Correction. Failure todispute or challenge the alleged deficiencies below is not an admission thatthe alleged facts occurred as presented in the statements.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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F 0159 SS=D Bldg. 00	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that			

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	receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.			
	Based on interview and record review, the facility failed to notify a resident or the resident's representative when resident funds balance was within $200.00 (two hundred dollars) of maximum Medicaid balance for 1 of 2 residents reviewed for notification of resident funds balance related to maximum Medicaid balance. (Resident #103) Findings include: Resident funds were reviewed with the Business Office Manager (BOM) on 3/14/16 at 9:50 a.m. During an interview at this time, the BOM indicated residents, who received Medicaid benefits, needed to be notified of their balance when the balance reached $1,800.00 (which is $200.00 below the maximum Medicaid balance of $2,000.00). Resident funds records indicated Resident #103 received Medicaid benefits. Resident funds records	F 0159	**F159** **Residents Effected** Resident #103 or the resident's representative has beennotified that the funds balance was within $200.00 (two hundred dollars) ofmaximum Medicaid balance. **Identification ofother residents** Current residents who have funds balances that was within$200.00 (two hundred dollars) of maximum Medicaid balance have been notified. **Systemic changes** The fund balances that are within $200.00 (two hundred dollars)of maximum Medicaid balance will be reviewed monthly. The facility will continue to monitor fund balancesongoing. The fund balances will bemonitored monthly by the Business Office Manager. The Business Office Manager will notify residents orresident's representative in writing who have fund balances that are within$200.00 (two hundred dollars) of maximum Medicaid balance. **Monitoring** The Business Office Manager will audit that fund balancesare within	03/29/2016

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	indicated Resident #103 had a 3/11/16 resident funds balance of $1,939.38. Review of Resident #103's "Resident Trust Ledger" for 2/1/16 to 3/4/16 indicated Resident #103's balance first exceeded $1,800.00 on 2/10/16 when Resident #103's balance reached $1,836.99. During a 3/14/16, 9:57 a.m., interview, the BOM indicated neither Resident #103 or her representative had been notified of a balance in excess of $1,800.00. During a 3/14/16, 12:31 p.m., interview, the BOM indicated the resident funds computer program did not have an alert for balances in excess of $1,800.00. She must manually check the balances each week. She additionally indicated she did not have a method where resident or family notification was documented. A current, 3/11/16, "Trust-Current Balance" form, provided by the BOM on 3/14/16 at 9:50 a.m., indicated the facility managed funds for 92 residents. Review of a current, undated, facility policy titled "Resident Trust Funds", which was provided by the BOM on 3/14/16 at 12:35 p.m., indicated the following: "Excess recourses-Medicaid eligible		$200.00 (two hundred dollars) of maximum Medicaid balance. The audit will be completed 1 time a week for2 weeks, bi-weekly for 4 weeks, and then ongoing monthly to maintain compliance. Audit results will be reviewed monthly in the QA meetingwith changes to the plan as deemed appropriate by the QA Committee.	

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	residents will be notified when the amount in the resident's account reached $200.00 less than Medicaid resource limit for one person...." 3.1-6(b)			
F 0161 SS=E Bldg. 00	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to maintain a surety bond of a sufficient amount to cover the balance of the resident funds balance. This deficient practices had the potential to effect the 92 residents for whom the facility managed funds. Findings include: During a 3/14/16,10:36 a.m., interview, the Administrator indicated the facility changed ownership on 2/1/16. A, 2/4/16, "Trial Balance", was provided by the Business Office Manager (BOM) on 3/14/16 at 10:41 a.m. It indicated the balance at the time of transfer on 2/1/16	F 0161	**F161** **Residents Effected** All residents that have funds may be affected. **Systemic changes** The current surety bond for resident funds indicating thebond for resident funds coverage in the amount of $50,000.00 (Fifty Thousanddollars) has been requested to be increased with the insurance company as of03/28/2016. Bank statement for the interest bearing account containingresident funds and ledger balance will be maintained within the surety bond. The Administrator/designee will ensure asurety bond has been established and maintained where the bond is at leastequal to the	03/29/2016

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	was $33,046.17. A current, 3/11/16, "Trust-Current Balance" form, was provided by the BOM on 3/14/16 at 9:50 a.m. It indicated the facility managed funds for 92 residents. The current, 2/22/16, surety bond for resident funds, which was provided by the BOM on 3/14/16 at 9:50 a.m., indicated the bond provided for resident funds coverage was in the amount of $50,000.00 (Fifty Thousand dollars). Review of the 2/9/16 to 2/29/16 bank statement for the interest baring account containing resident funds indicated the ledger balance was in excess of $50,000.00 on the following days: 2/10/16 - $58,922.04 which was $8,922.04 more than the surety bond covered. 2/19/16 - $98,851.52 which was $48,851.52 more than the surety bond covered. 2/29/16 - $ 98,637.22 which was $48,637.22 more than the surety bond covered. Review of a current, undated, facility policy titled "Resident Trust Funds", which was provided by the BOM on 3/14/16 at 12:35 p.m., indicated the		amount of the residents' funds combined. **Monitoring** The Business Office Manager will audit that resident fundsare within the surety bond. The auditwill be completed 1 time a week for 2 weeks, bi-weekly for 4 weeks, and thenongoing monthly to maintain compliance. Audit results will be reviewed monthly in the QA meetingwith changes to the plan as deemed appropriate by the QA Committee.	

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	following: "Surety Bonds - The facility Administrator will ensure a surety bond has been established and maintained where the bond is at least equal to the amount of the residents' funds combined." 3.1-6(j)			
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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).			

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	The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the State Agency and failed to conduct a thorough investigation of an allegation of abuse for 1 of 15 residents interviewed regarding abuse. (Resident #84) Findings include: During an interview on 3/8/16 at 2:02 p.m., Resident #84 indicated a male CNA had touched her breast approximately 9 months ago. Resident #84 indicated she had informed the staff about the male CNA touching her breast. During an interview on 3/9/16 at 9:40 a.m., the Administrator indicated he found an investigation regarding Resident #84 and an abuse allegation dated 8/19/15. The Administrator further	F 0225	***Residents Affected*** On 8/19/16, an allegation from resident #84 was investigatedby the interim administrator and not substantiated. On 3/22/16, the resident was re-interviewed regardingthe allegation, as well as other like residents that received care from thealleged C.N.A. The incident report wasre-opened by the facility and did not substantiated and was reported to theState on 3/28/16. ***Identification of Other Residents*** Residents from the unit where incident occurred andpotentially received care from the alleged C.N.A. who are alert and oriented(BIM >3) were interviewed regarding any concerns with treatment from staffand no concerns were reported. ***Systemic Changes*** The interimadministrator is no longer working at the facility. The current administrator provided	03/29/2016

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	indicated he was unable to retrieve from the State Agency any documentation from the previous Administrator to indicate an abuse allegation, dated 8/19/15, had been reported. On 3/9/16, at 9:40 a.m., the abuse allegation investigation involving Resident #84 was provided by the Administrator. The investigation, dated 8/19/15, indicated Resident #84, Resident #84's roommate at the time of the allegation, and the male CNA named in the allegation were interviewed and statements obtained. The investigation lacked any additional interviews and/or statements from residents the male CNA provided care for, and additional staff members. The investigation lacked any indication of the abuse allegation, dated 8/19/15, having been reported to the State Agency. During an interview on 3/14/16 at 3:44 p.m., the Administrator indicated he had no other documentation to provide regarding the investigation of Resident #84's abuse allegation. Review of the current, revised 2/14/16 policy, titled "Abuse Prevention Program", provided by the Administrator on 3/14/16 at 12:42 p.m., included, but was not limited to, the following:		additionalinvestigations to the state surveyors during the annual survey to indicate heis familiar and compliant with reporting expectations. Inservice to managers was provided on 3/28/16to all managers to re-educate the policy to report allegations from residentsregarding abuse. ***Monitoring*** All abuse allegations and investigations will be reviewedweekly for four weeks, and then monthly for six months and reported at QAmeetings for compliance and recommendations.	

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	"...f. Timely and thorough investigations of all reports and allegations of abuse... ...Reporting Abuse to State Agencies and Other Entities/Individuals... ...All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law... ...Should a suspected violation or substantiated incident of mistreatment, neglect, inquiries of an unknown source or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility...." 3.1-28(a) 3.1-28(c) 3.1-28(d)			

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F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 the facility policy was implemented in regards to timely reporting and thorough investigation of an abuse allegation for 1 of 15 residents interviewed regarding abuse (Resident #84). This deficient practice had the potential to impact 1 of 3 incidents reviewed for abuse. Findings include: During an interview on 3/9/16 at 9:40 a.m., the Administrator indicated he found an investigation regarding Resident #84 and an abuse allegation dated 8/19/15. The Administrator further indicated he was unable to retrieve from the State Agency any documentation from the previous Administrator to indicate an abuse allegation, dated 8/19/15, had been reported. On 3/9/16, at 9:40 a.m., the abuse allegation investigation involving Resident #84 was provided by the Administrator. The investigation, dated	F 0226	***Residents Affected*** On 8/19/16, an allegation from resident #84 was investigatedby the interim administrator and not substantiated. On 3/22/16, the resident was re-interivewed regardingthe allegation, as well as other like residents that received care from thealleged C.N.A. The incident report wasre-opened by the facility and did not substantiated and was reported to theState on 3/28/16. ***Identification of Other Residents*** Residents from the unit where incident occurred andpotentially received care from the alleged C.N.A. who are alert and oriented(BIM >3) were interviewed regarding any concerns with treatment from staffand no concerns were reported. ***Systemic Changes*** The interimadministrator is no longer working at the facility. The current administrator provided additionalinvestigations to the state surveyors during the annual survey to indicate heis familiar and compliant with reporting expectations. Inservice to managers was provided on 3/28/16to all managers to	03/29/2016

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	8/19/15, indicated Resident #84, Resident #84's roommate at the time of the allegation, and the male CNA named in the allegation were interviewed and statements obtained. The investigation lacked any additional interviews and/or statements from residents the male CNA provided care for and additional staff members. The investigation lacked any indication of the abuse allegation, dated 8/19/15, having been reported to the State Agency. During an interview on 3/14/16 at 4:16 p.m., the Administrator indicated the current facility census was 125. During an interview on 3/14/16 at 3:44 p.m., the Administrator indicated he had no other documentation to provide regarding the investigation of Resident #84's abuse allegation. Review of the current, revised 2/14/16 policy, titled "Abuse Prevention Program", provided by the Administrator on 3/14/16 at 12:42 p.m., included, but was not limited to, the following: "...Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion....		re-educate the policy to report allegations from residentsregarding abuse. ***Monitoring*** All abuse allegations and investigations will be reviewedweekly for four weeks, and then monthly for six months and reported at QAmeetings for compliance and recommendations.	

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	...f. Timely and thorough investigations of all reports and allegations of abuse; g. The reporting and filing of accurate documents relative to incidents of abuse;..." 3.1-28(a)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to prepare, store, and distribute food under clean and sanitary conditions. This deficient practice had the potential to effect 113 residents that received meal service from the kitchen. Findings include: The initial kitchen tour was made on 3/7/16 at 9:27 a.m. to 10:03 a.m., with the Dietary Manager present. The bottom of the steam oven had a black build up from spills. The dietary manager	F 0371	***Affected Systems*** On 3/14/16 the can opener, mixer bowls, white storage bins,metal storage racks, floor of the storage room, top of the dish machine,grooves on the toaster, crumbs around the toaster, steam toaster and drystorage heater & ceiling vent were cleaned and the stand mixer wascovered. The sanitizing dishwashingmachine was professionally serviced on 3/12/16 and temps were recorded above180 degrees. ***Identification of Other Systems*** All residents in the facility who receives an oral diet hadthe	03/29/2016

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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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	indicated it was not on a cleaning schedule. The can opener blade was soiled with dried dark debris. Dietary Staff #1 indicated the can opener had not been used that morning. The Dietary Manager indicated the can opener should have been cleaned every night. The stand mixer was not covered and the bowl was in place ready for use. The bottom of the bowl had debris in it. The Dietary Manager indicated the mixer should have been covered. There were two white plastic storage bins for sugar and flour stored under a counter. Both bins had red spills on the lids, around the rims and down the sides. The Dietary Manager indicated drinks were poured at the counter above the bins and liquids would spill down on them. The dry storage room heater vent and ceiling vent had heavy dust build up. The nine metal storage racks had debris and soil build up on them. The floor was dirty and had loose debris on it. The Dietary Manager indicated the floor was only swept after delivery. There had been no delivery that morning. The top of the dish machine had a heavy lime build up and debris. The machine was a high temperature sanitizing machine and indicated the rinse cycle should be 180 to 190 degrees. The		potential to be affected. Nopositive symptoms related to food-borne illness were reported. On 3/24/16 thru 3/25/16, all dietary staff were in-servicedby the dietary manager on the importance of storing, preparing, and servingfood in a sanitary manner and given the updated cleaning schedule. Dietary staff were inserviced on 3/14/16 to educate therequirement to sanitize the dishes in a sink of quat solution in the event thatthe dish rinse temp did not reach 180 degrees. The machine repairman phone number was also placed on the dish washingmachine and staff inserviced to call if the temperatures were ever below 180degrees. ***Systemic Changes*** On 3/25/16 a new comprehensive kitchen cleaning schedule wasupdated and inserviced to the staff. Anaudit of the cleaning schedule is to be reviewed by the dietary manager orassistant dietary manager daily. On 3/25/16, a daily log report that shows any temperaturesfrom the dish rinse cycle that are below 180 degrees was initiated. ***Monitoring*** The dietary manager will audit these logs weekly for 4 weeks,bi-weekly for 4 weeks and then monthly for 6 months and report to the QualityAssurance Committee Meetings for compliance review and recommendations.	

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 03/14/2016
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	machine would not go above 176 degrees. The kitchen was observed on 3/11/16 at 10:37 a.m., with the Dietary Manager present. The grooves of the toaster knobs were caked with black grime and there was a heavy accumulation of toast crumbs under the toaster and on the floor around the cart the toaster sat on. The Dietary Manager indicated the toaster was wiped down every morning after use. The steam table by the service window had dried yellow spills on the lower shelf and the service ledge had dried white spills and food crumbs and debris. The Dietary Manager indicated the staff were learning new menus and did not have time to clean. The red spills remained on lids, rims and sides of the two white plastic storage bins. The hand written "Cleaning List" for the weekend of 3/5/16 and 3/6/16 was provided by the Dietary Manager on 3/11/16 at 11:50 a.m. The list indicated the following to be cleaned: steam tables, toaster, microwave, desert carts, dishroom, trash cans, stove and steamer, refrigerators, pots and pan room, take out empty boxes, rotate stock, and empty boxes of new stock. The Dietary Manager indicated the facility did not have routine daily and weekly cleaning			

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	schedules. She indicated her assistant would hand write schedules for cleaning to be done on the weekends. During an interview with the Dietary Manager on 3/11/16 at 11:15 a.m., she indicated the facility did not use a sanitizer in the dishmachine. She indicated she thought the drying agent was a sanitizing product. The Dietary Manager provided the dishmachine temperature logs on 3/11/16 at 11:50 a.m., and indicated the temperature was checked twice a day. The log indicated the rinse temperatures were as follows: 3/3/16 at 10:00 a.m. - 160 degrees 3/4/16 at 7:00 p.m. - 170 degrees 3/5/16 at 9:00 a.m. - 167 degrees 3/5/16 at 1:00 p.m. - 164 degrees 3/6/16 at 9:00 a.m. - 168 degrees 3/6/16 at 1:00 p.m. - 170 degrees 3.1-21(i)(3)			