

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155247	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/14/2011
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN46227
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 11, 12, 13 & 14, 2011</p> <p>Facility number: 000151 Provider number: 155247 AIM number: 100284060</p> <p>Survey team: Marcy Smith, RN- TC Courtney Mujic, RN Beth Kolasa, RN Karina Gates, Medical Surveyor</p> <p>Census bed type: SNF: 41 SNF/NF: 83 Total: 124</p> <p>Census payor type: Medicare: 23 Medicaid: 57 Other: 44 Total: 124</p> <p>Sample: 24</p> <p>These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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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F0279 SS=E	<p>Quality review completed on October 18, 2011 by Bev Faulkner,RN</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on clinical record review and interview, the facility failed to ensure care plans were created for care areas triggered by the MDS (Minimum Data Set) for 7 of 14 residents in a total sample of 24. Residents #3, #31, #59, #65, #56, #117, #19.</p> <p>Findings include:</p>	F0279	<p>F 279</p> <p>It is the practice of Manor Care Indy South to provide each resident with a comprehensive care plan that includes measurable objectives</p>	11/07/2011

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	<p>1. Resident #3's clinical record was reviewed on 10/12/2011 at 9:45 a.m. The record contained documentation of Resident #3 having been admitted to the facility on 8/27/2007. The record contained diagnoses that included, but were not limited to, arthritis, dementia, and depression.</p> <p>The 8/17/2011 MDS (Minimum Data Set) for Resident #3 indicated the care areas for activities of daily living and visual function were triggered and care plans were created. No care plans for activities of daily living and visual function could be found in the clinical record.</p> <p>During interview with the Administrator and Director of Nursing on 10/12/2011 at the daily conference at 4:20 p.m., they were informed of the missing vision and activities of daily living care plans for Resident #3. No further information or documentation was provided.</p> <p>2. Resident #31's clinical record was reviewed on 10/13/2011 at 11:00 a.m. The record contained documentation of Resident #31 having been admitted to the facility on 7/7/2011. The record contained diagnoses that included, but were not limited to, osteoporosis, atherosclerosis, and history of falls.</p>		<p>and timelines to meet resident's medical, nursing and psychosocial needs.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident # 3, 31, 59, currently have revised and updated ADL and Visual Function care plans, Resident # 65 has a revised and updated care plan on visual function, Resident # 56 currently has a revised and updated care plan for ADL functional/rehabilitation potential, Resident # 117 has a revised and updated care plan for dental care and Resident # 19 has a completed plan of care for communication.</p> <p>How other residents having the potential to</p>	

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	<p>The 7/14/2011 MDS (Minimum Data Set) for Resident #31 indicated the care areas for activities of daily living and visual function was triggered and care plans were created. No care plan for activities of daily living and visual function could be found in the clinical record.</p> <p>Interview with RN #2 on 10/13/2011 at 1:30 p.m., indicated that the activities of daily living and vision care plans for Resident #31 were not completed.</p> <p>3. Resident #59's clinical record was reviewed on 10/13/2011 at 3:30 p.m. The record contained documentation of Resident #59 having been admitted to the facility on 8/8/2011. The record contained diagnoses that included, but were not limited to, lymphedema, deep vein thrombosis, lower leg cellulitis, and depression.</p> <p>The 8/25/2011 MDS for Resident #59 indicated the care areas for activities of daily living and visual function were triggered and care plans were created. No care plan for activities of daily living and visual function could be found in the clinical record.</p> <p>During an interview with the Director of Nursing on 10/14/2011 at 1:20 p.m., she</p>		<p>be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>A chart review of residents with care plans for visual function, ADLs, dental, and ADL functional/rehabilitation, and communication were reviewed and updated on all necessary residents.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The IDT has been in-serviced on developing, reviewing and revising the comprehensive plan of care based on results of the assessment”</p> <p>How will the corrective actions be monitored to ensure that they do not</p>	

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	<p>indicated the activities of daily living and visual function care plans for Resident #59 were not done.</p> <p>4. The clinical record for Resident #65 was reviewed on 10/11/11 at 1:00 p.m.</p> <p>The diagnoses for Resident #65 included, but were not limited to: glaucoma, depression, cognitive dysfunction, and anxiety.</p> <p>The 8/20/11 admission MDS (Minimum Data Set) for Resident #65 indicated the care area for visual function was triggered and a care plan was created. No care plan for visual function could be found in the clinical record.</p> <p>During interview with the DON (Director of Nursing) on 10/13/11 at 12:15 p.m.,</p>		<p>reoccur?</p> <p>A QA audit tool will be completed by ADNS/Designee on 10 random charts a week times four weeks to ensure that care plans are completed and accurate. The results will be reviewed by QA committee monthly.</p> <p>By what date will the changes occur?</p> <p>11/7/2011</p>		

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	<p>she indicated there was no care plan for visual function for Resident #65. At this time, the DON provided a care plan for visual function for Resident #65 initiated 10/13/11.</p> <p>5. The clinical record for Resident #56 was reviewed on 10/12/11 at 10:00 a.m.</p> <p>The diagnoses for Resident #56 included, but were not limited to: neuropathy, degenerative joint disease, and history of cataracts.</p> <p>The 4/23/11 admission MDS (Minimum Data Set) for Resident #56 indicated the care area for ADL (activities of daily living) functional/rehabilitation potential was triggered and a care plan was created. No care plan for ADL functional/rehabilitation potential could be found in the clinical record.</p> <p>During interview with the DON (Director of Nursing) on 10/13/11 at 12:15 p.m., she indicated there was no care plan for ADL functional/rehabilitation potential for Resident #56. At this time, the DON provided a care plan for ADL functional/rehabilitation potential for Resident #56 initiated 10/13/11.</p> <p>6. The record of Resident #117 was reviewed on 10/12/11 at 10:30 a.m.</p>				

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	<p>Diagnoses for Resident #117 included, but were not limited to, coronary artery disease, legal blindness and gastroesophageal reflux disease.</p> <p>An admission MDS, dated 8/13/11, for Resident #117 indicated the care area for dental was triggered and a care plan was created. No dental care plan could be found in the resident's record.</p> <p>During an interview with RN #2 on 10/13/11 at 1:30 p.m., she indicated Resident #117 did not have a dental care plan.</p> <p>7. The record of Resident #19 was reviewed on 10/11/11 at 1:20 p.m.</p> <p>Diagnoses for Resident #19 included, but were not limited to, depression, dementia and coronary artery disease.</p> <p>A significant change MDS dated 8/24/11 for Resident #19 indicated the care area for communication was triggered and a care plan was created. No care plan for communication could be found in the resident's record.</p> <p>During an interview with the DON on 10/14/11 at 1:00 p.m., she indicated Resident #19 did not have a communication care plan.</p>				

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F0282 SS=D	<p>3.1-35(a)</p> <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 observation, interview, and record review, the facility failed to ensure a medication was discontinued, a house supplement was given, and double portions of food were provided per M.D. orders. This affected 2 of 24 residents in a total sample of 24 reviewed for following physician's orders. (Resident #65 and Resident #117)</p> <p>1.a. The clinical record for Resident #65 was reviewed on 10/11/11 at 1:00 p.m.</p> <p>The diagnoses for Resident #65 included, but were not limited to: Depression, Cognitive Dysfunction, and Anxiety.</p> <p>A physician's order, dated 9/28/11 at 3:25</p>	F0282	<p>F 282</p> <p>It is the practice of Manor Care Indy South for all services either provided or arranged by the facility to be provided by qualified persons in accordance with the resident's written plan of care.</p> <p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident # 65 and # 117</p>	11/07/2011	

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	<p>p.m., indicated D/C (discontinue) Remeron. The September and October, 2011 MAR (Medication Administration Records) indicated Resident #65 received Remeron daily at 9:00 p.m., on 9/28/11 through 10/10/11. The MAR's were initialed by staff on each of these days indicating they had given the Remeron.</p> <p>During interview with the DON (Director of Nursing) on 10/11/11 at 2:15 p.m., she indicated the Remeron for Resident #65 should have been discontinued on 9/28/11 and it was not. On 10/12/11 at 9:30 a.m., the DON provided a copy of a nurse's note, dated 10/11/11 at 2:35 p.m., indicating the M.D. and family were notified of the medication error.</p> <p>b. The October, 2011 physician's recapitulation orders for Resident #65 indicated a house supplement to be given TID (three times daily) with meal trays at 9:00 a.m., 11:00 a.m., and 5:00 p.m.</p> <p>During observation of the lunch meals on 10/12/11 at 11:35 a.m., and 10/14/11 at 11:40 a.m., Resident #65 was not observed with a house supplement on her meal tray. During interview with RN #1 on 10/14/11 at 11:42 a.m., she indicated Resident #65 should have been served a house supplement with her meal tray and was not. RN #1 proceeded to order the</p>		<p>were immediately provided with ordered nourishments.</p> <p>Resident #65 medication was discontinued on 10/11/11. Resident's family and physician were notified.</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>The Dietician will audit charts in the facility to ensure that the physician's orders are matching the orders available to the dietary staff.</p> <p>A chart review was completed for residents on double portions and house supplements. All tray cards were updated to match orders.</p>	

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	house supplement.		<p>A medication review was completed to ensure residents' current medications had a current physician order.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Nursing and Dietary staff will receive in-service on checking the resident's diet card prior to serving the tray.</p> <p>Licensed Nurses will be in-serviced on Medication Administration and Following Physician Orders.</p> <p>How will the corrective actions be monitored to ensure they do not occur again?</p> <p>A QAA audit tool will be completed Dietary Manager/Designee on</p>		

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	<p>2. The record of Resident #117 was reviewed on 10/12/11 at 10:30 a.m.</p> <p>Diagnoses for Resident #117 included, but were not limited to, dementia, gastroesophageal reflux disease and coronary artery disease.</p> <p>A care plan for Resident #117, initiated 8/9/11 and updated 9/25/11, indicated Resident #117 had a potential for altered</p>		<p>tray accuracy. This will be completed weekly times four weeks. The results will be reviewed by QAA committee monthly. A QAA audit tool will be completed by ADNS/Designee on medication administration and following Physician orders. This will be completed weekly times four weeks. The results will be reviewed by QA committee monthly.</p> <p>By what date will the changes occur? 11/7/2011</p>		

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	<p>nutritional status secondary to ... "underweight" and ... "recent additional wt. [weight] loss since admission..." A goal was "Will be well nourished as evidenced by maintaining current body weight with goal of gradual weight gain." An intervention, created 10/5/11, was "Patient may have double portions at all meals per order."</p> <p>A review of Resident #117's weights indicated he weighed 140 pounds (lbs) on his admission to the facility on 8/7/11 and on 10/1/11 he weighed 131.8 lbs. This is a 5.7% weight loss in 2 months. A review of dietary notes and recommendations since his admission indicated the dietician was aware he was losing weight and interventions had been put in place. A dietary recommendation and physician's order, dated 10/4/11, indicated Resident #117 was to receive double portions of a mechanical soft diet at meal times secondary to having increased caloric needs.</p> <p>During a lunch meal observation on 10/12/11 at 11:30 a.m., Resident #117's portions appeared the same size as the portions of the other residents at his table. His meal ticket on his tray indicated "double portions." During an interview with the Unit Manager, RN #1, on 10/12/11 at 11:40 a.m., she indicated the</p>				

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F0329 SS=D	<p>food on Resident #117's tray "doesn't appear to be double portions."</p> <p>3.1-35(g)(2)</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a GDR (Gradual Dose Reduction) was considered for an antidepressant medication (Resident #19) and pre and post pain assessments were done prior to the administration of pain medication (Residents #82 and 93) for 3 of 11 residents reviewed for unnecessary medications in a sample of 24.</p>	F0329	<p>F329</p> <p>It is the practice of Manor Care Indy south to provide a drug regimen free from unnecessary medications for all residents.</p> <p>What corrective action</p>	11/07/2011	

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	<p>Findings included:</p> <p>1. The record of Resident #19 was reviewed on 10/11/11 at 1:20 p.m. He was admitted to the facility on 1/23/04.</p> <p>Diagnoses for Resident #19 included, but were not limited to, depression and dementia.</p> <p>A recapitulated physician's order for October, 2011, with an original order date of 10/20/09, indicated Resident #19 should receive Celexa (an antidepressant medication) 10 milligrams every day.</p> <p>Record review did not indicate a GDR had been attempted or considered for the Celexa for Resident #19.</p> <p>Further information was requested from the Director of Nursing (DoN) on 10/11/11 at 2:40 p.m., regarding a GDR for Celexa for Resident #19.</p> <p>On 10/13/11 at 10:45 a.m., the DoN indicated she could not find any information regarding whether a GDR had been considered or attempted for Resident #19's Celexa.</p>		<p>will be accomplished for those residents who have been affected by the deficient practice?</p> <p>Resident #19 was seen by his primary care physician with documentation that a GDR was not recommended and is contraindicated for this resident related to his being on Hospice and Depressed.</p> <p>A Pain Assessment has been completed on Resident #82 and #93.</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 review was completed by Social Service to identify residents that require a GDR. Once identified a</p>		

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			<p>GDR will be performed or documented as contraindicated by physician or designee. Residents with ordered PRN pain medication were reviewed for pain management and updated Pain Assessment completed if needed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Social Service and Licensed Nurses were educated about the GDR process.</p> <p>Licensed Nurses will be in-serviced on Pain Management, Medication Administration and Medication Documentation</p> <p>How will corrective actions be monitored to</p>		

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	#2. The clinical record for Resident #82 was reviewed on 10/11/11 at 12:50 p.m. The diagnosis for Resident #82 included, but was not limited to: colon cancer with		ensure that they do not reoccur? A QA audit tool will be completed by Social Services/Designee on residents that may require a GDR to ensure completion of GDR. This will be completed weekly times four weeks the results will be reviewed by QA committee monthly. A QA audit tool will be completed by ADNS/Designee on pain management. This will be completed weekly times four weeks. The results will be reviewed by QA committee monthly. By what date will the changes occur? 11/7/2011		

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	<p>colostomy, left ureter stent, and recurrent urinary tract infection.</p> <p>The September 2011 MAR (Medication Administration Record) was reviewed on 10/11/11 at 12:50 p.m. It indicated Hydrocodone 5/325 was given on 9/12/11 (no time indicated), 9/20/11 (no time indicated), and 9/25/11 (no time indicated). There was no documentation to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given.</p> <p>Resident #82's care plan for pain was reviewed on 10/13/11 at 11:30 a.m. The care plan indicated an approach was to observe effectiveness of PRN (as needed) medications.</p> <p>In a policy received on 10/14/11 at 8:30 a.m., from the DoN (Director of Nursing), the policy indicated "...Identification and evaluation of a patient's response to the plan of care is necessary until it is determined that the patient's pain is resolved....This can be done by utilizing several different monitoring and tracking systems...Documentation of medication effectiveness on the Medication Administration Record."</p>				

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	<p>#3. The clinical record for Resident # 93 was reviewed on 10/14/11 at 9:40 p.m.</p> <p>The diagnosis for Resident #93 included, but was not limited to: humerus fracture and femur fracture.</p> <p>The September 2011 MAR (Medication Administration Record) was reviewed on 10/14/11 at 9:40 p.m. It indicated acetaminophen 325mg (milligram) was given on 9/16/11 (no time indicated). There was no documentation to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given.</p> <p>Resident #93's care plan for pain was reviewed on 10/14/11 at 12:30 p.m. The care plan indicated an approach was to observe effectiveness of PRN (as needed) medications.</p> <p>In a policy received on 10/14/11 at 8:30 a.m. from the DoN (Director of Nursing), the policy indicates "...Identification and evaluation of a patient's response to the plan of care is necessary until it is determined that the patient's pain is resolved....This can be done by utilizing several different monitoring and tracking systems...Documentation of medication</p>				

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F0425 SS=D	<p>effectiveness on the Medication Administration Record."</p> <p>3.1-48(a)(2) 3.1-48(a)(3)</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>A. Based on observation and interview, the facility failed to ensure 1 of 6 insulins were disposed of prior to or on the expiration date. This had the potential to affect 1 of the 4 residents (Resident #75) receiving insulin from the med cart. The facility also failed to ensure 2 of 4 Advair inhalers were disposed of prior to or on the expiration date. This had the potential to affect 2 of 4 residents (Residents #15,</p>	F0425	F 425 It is the practice of Manor care Indy South to provide all residents with pharmaceutical services to meet their individual needs. MCIS does employ a licensed pharmacist	11/07/2011

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	<p>#87).</p> <p>B. Based on record review and interview, the facility failed to ensure they accounted for the disposition of medications of a discharged resident for 1 of 3 residents reviewed for the disposition of their medications upon discharge in a sample of 24. (Resident #126)</p> <p>Findings include:</p> <p>A.1. The West A Hall medication cart was reviewed with LPN #1 on 10/13/11 at 3:15 p.m.</p> <p>The West A Hall medication cart contained Lantus 100 units/ml (milliliter) for resident #75. The bottle was dated 9/2/11 as the open date. In a phone interview on 10/14/11 at 12:30 p.m., with a pharmacist from the facility's contracted pharmacy, the pharmacist indicated Lantus expires within 28 days from the open date.</p> <p>The West A Hall medication cart contained Advair 250/50 for Residents #15, dated 9/9/11 as the open date, and Resident #87's Advair 250/50, dated 9/5/11 as the open date. The package insert titled "Prescribing Information...Advair Diskus...250/50..." dated June, 2010, indicated that Advair</p>		<p>who provides consultation on all aspects of the provision of pharmacy services within the facility.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 75, #15, and #87 were assessed and no adverse reaction noted. Physician and families aware.</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>Medication in Medication carts and Medication rooms were audited for expiration date.</p> <p>What measures will be</p>		

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	<p>expires within 30 days from opening the packaging.</p> <p>In an interview with the DoN (Director of Nursing) on 10/14/11 at 9:30 a.m., she indicated the expiration dates for insulin and inhalers are what the manufacturer's guidelines indicate.</p> <p>B.1. The record of Resident #126 was reviewed on 10/14/11 at 10:55 a.m.</p> <p>Resident #126's medications included, but were not limited to, Omeprazole, (a medication for relief of gastroesophageal reflux), Ambien. (a sleep medication) and Tylenol. (a pain reliever).</p> <p>Resident #126 was discharged to home on 7/7/11.</p> <p>Record review did not indicate Omeprazole, Ambien or Tylenol were returned to the pharmacy, sent home with the resident or destroyed in the facility.</p> <p>During an interview with the Director of Nursing on 10/14/11 at 1:20 p.m., she indicated she didn't know what happened to the Omeprazole, Ambien or Tylenol. She indicated they had "no documentation" of their disposition.</p>		<p>put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>MCIS has both a consultant pharmacist as well as a pharmacy assistant that comes in monthly and audits resident's charts and medication carts.</p> <p>Licensed nursing staff will be in-serviced on the appropriate expiration dates for all medications and appropriate documentation of medication disposition.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>Medication Cart and Medication Rooms will be audited by ADNS/Designee weekly to</p>		

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	3.1-25(o) 3.1-25(s)(1) 3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)		check for expired medication. Audit will be completed by ADNS/Designee on discharged charts for documentation of medications disposition. This will be completed weekly times four weeks the results will be reviewed by QA committee monthly. Date to be completed 11/7/2011		

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F0431 SS=D	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review and interview, the facility failed to ensure they accounted for the disposition of a controlled medication of a discharged resident for 1 of 3 residents reviewed for the disposition of their controlled medications upon discharge in a sample of 24. (Resident #126)</p>	F0431	<p>F431</p> <p>It is the policy of Manor care Indy south to properly dispose of all medications to include narcotics, of both current</p>	11/07/2011

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	<p>Findings included:</p> <p>The record of Resident #126 was reviewed on 10/14/11 at 10:55 a.m.</p> <p>Resident #126's medications included, but were not limited to, Norco. (a narcotic pain medication)</p> <p>Resident #126 was discharged to home on 7/7/11.</p> <p>Record review did not indicate Norco was returned to the pharmacy, sent home with the Resident #126 or destroyed in the facility.</p> <p>During an interview with the Director of Nursing on 10/14/11 at 1:20 p.m., she indicated she didn't know what happened to the Norco. She indicated they had "no documentation" of the disposition.</p> <p>3.1-25(s)(1) 3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)</p>		<p>and discharged residents.</p> <p>What corrective action will be taken for those resident found to have been affected by the deficient practice?</p> <p>Resident # 126 was discharged to home.</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>Medication disposition forms will be completed for discharging residents.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Licensed nursing staff will be in-serviced on the appropriate documentation of</p>	

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			<p>medication disposition.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>Audit discharged charts by ADNS/Designee for documentation of medications disposition. This will be completed weekly times four weeks. The results will be reviewed by QA committee monthly.</p> <p>Date to be completed 11/7/2011</p>		

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F0441 SS=D	<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. A. Based on interview and record review, the facility failed to ensure a 2 step Tuberculin skin test was administered to a new resident for 1 of 8 residents reviewed for having a Tuberculin skin tests</p>	F0441	F 441 It is the policy of Manor care Indy South to maintain an Infection	11/07/2011	

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	<p>administered in a sample of 24. (Resident #2)</p> <p>B. Based on observation and record review, the facility failed to ensure hand hygiene practices were followed after urinary catheter care 1 of 1 residents observed for catheter care in a sample of 24. (Resident #82)</p> <p>Findings included:</p> <p>A.1. The record of Resident #2 was reviewed on 10/13/11 at 8:45 a.m.</p> <p>Diagnoses for Resident #2 included, but were not limited to, acute respiratory failure, tracheostomy, acute pancreatitis, chronic obstructive pulmonary disease and aspiration pneumonia.</p> <p>Resident #2 was admitted to the facility from a hospital on 9/21/11. The record indicated a tuberculin skin test was administered on 9/21/11 with negative results. The record did not indicate a 2nd step skin test was given.</p> <p>Further information was requested from the Director of Nursing regarding a 2nd step tuberculin skin test for Resident #2 on 10/12/11.</p> <p>During an interview with RN Unit</p>		<p>control program to provide safe, sanitary and comfortable environment to help prevent the transmission of disease and infection.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice?</p> <p>Resident # 2 did not receive her second step ppd timely. The resident did however have a first step and a chest x-ray to which ruled out the resident having TB. The facility did however repeat both her first and second step ppd to provide the accurate necessary documentation. This was to be completed 1 to 3 weeks after the first step was read negative. Resident # 82 was assessed for signs and</p>		

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	<p>Manager #2 on 10/13/11 at 1:10 p.m., she indicated she was unable to find documentation to indicate a 2nd step tuberculin skin test had been administered to Resident #2.</p> <p>During an interview with the Director of Nursing on 10/14/11 at 1:30 p.m., she indicated the facility followed the Indiana State Department of Health policy regarding the administration of tuberculin skin tests to long term care residents.</p> <p>A review of "Article 16.2. Health Facilities: Licensing and Operational Standards...410 IAC 16.2-3.1-18 Infection control program...Sec. 18" indicated "... (f)...the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test..."</p>		<p>symptoms of infection</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>Residents were reviewed for accurate TB screening. Residents with catheter have been assessed for sign and symptoms of infection.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Licensed Nursing staff will be in-serviced TB administration guidelines. Nursing staff will be in-serviced on infection control policies. The nursing assistant that provided the care to</p>		

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			<p>resident # 82 has been re-educated on the appropriate way to complete catheter care and dispose of supplies when completed..</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>A QA audit tool will be completed by ADNS or designee on new admits to ensure placement of 2-step ppd. Audit will be completed by ADNS or designee weekly times four weeks. The results will be reviewed by QA committee monthly.</p> <p>A QA audit will be completed by ADNS or designee for infection control during catheter care. This will be completed weekly times four weeks and then</p>		

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	<p>B.1. During an observation of CNA #1 performing catheter care on Resident #82 on 10/12/11 at 2:40 p.m., CNA #1 did not take off her gloves after completing catheter care. CNA #1 touched the bed control with her gloves.</p> <p>In a policy for catheter care received on 10/13/11 at 9:15 a.m., from the DoN (Director of Nursing), the policy indicated once catheter care has been completed "...clean, dispose, of supplies and equipment as needed ...remove gloves and perform hand hygiene."</p> <p>In a policy for standard precautions from the infection control manual received on 10/14/11 at 12:45 p.m., from the Administrator, the policy indicates "...wash hands or use waterless hand sanitizer upon completion of patient contact...change gloves between tasks."</p> <p>3.1-18(f) 3.1-18(l)</p>		<p>monthly times three months. The results will be reviewed by QA committee monthly. Date to be completed. 11/7/2011</p>		

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate documentation in regards to a GDR (gradual dose reduction) consideration for 1 of 24 residents (Resident #4) and disposition of personal belongs for 2 of 3 residents (Residents #127 and 125) in a total sample of 24.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #4 was reviewed on 10/12/11 at 2:00 p.m.</p> <p>The diagnoses for Resident #4 included, but were not limited to: depression.</p> <p>The October, 2011 physician's recapitulation order indicated Citalopram 20 mg, a generic medication for Celexa,</p>	F0514	<p>F 514</p> <p>It is the policy of Manor Care Indy South to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurate, accessible, and systematically organized.</p> <p>What corrective action will take place for those residents affected by the deficient practice?</p> <p>Resident # 4 had been considered for a GDR</p>	11/07/2011

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	<p>to be given daily at 9:00 a.m. with a begin date of 1/3/11.</p> <p>The January, 2011 MAR (Medication Administration Record) indicated Celexa 20 mg was administered to Resident #4 daily at 9:00 a.m., beginning 1/4/11.</p> <p>No information could be found in the clinical record indicating a GDR was considered on the Celexa. When queried about this on 10/13/11 at 2:50 p.m., Nurse Practitioner #1 indicated she did consider a GDR on the Celexa on 9/29/11, but did not document the consideration.</p> <p>The DON provided a copy of the 9/29/11 Nurse Practitioner progress note with a 10/13/11 addendum indicating no GDR on Celexa secondary to patient tearful on exam.</p> <p>2. The record of Resident #127 was reviewed on 10/14/11 at 12:30 p.m.</p> <p>Resident #127 was admitted to the facility on 6/9/11 and passed away at the facility on 7/30/11.</p> <p>Review of an "Inventory of Personal Effects," dated 6/9/11, indicated Resident #127 brought the following items to the facility for her personal use: 1 brassiere, 1 glasses, 1 pair of hose, 1 housecoat, 1</p>		<p>however the nurse practitioner did not document this in her note. The Director of Nursing and the Administrator met with the nurse practitioner as well as the physician and discussed the need for documentation when GDR are considered or actually done.</p> <p>The nurse practitioner has since documented that she feels a GDR on Celexa is not indicated at this time. She will re-examine and document per policy. Resident # 127 and # 125 did not have signed acknowledgement of his belongings being returned at Discharge. Resident # 125 has since returned to facility for additional rehabilitation to home. His family stated that they had in fact taken all</p>				

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	<p>robe, 2 pairs of slacks, 1 pair of socks, 1 toothbrush, 2 pairs of underwear and a yellow blanket. Her signature at the bottom of the list, under "On Admission/Move-in," indicated it was a "correct listing."</p> <p>Nursing notes from 7/30/11 indicated Resident #127's glasses were sent home with the family. On this same inventory sheet there was an area labeled "On Discharge/Move-Out Upon discharge/move-out, personal items are sent with the resident/patient or picked up by responsible party....Signature of Resident / Patient / Responsible Party." There was no signature in this area to indicate the resident's belongings had been given to a responsible party.</p> <p>During an interview with the Administrator on 10/14/11 at 1:10 p.m., he indicated "We don't have an acknowledgement of the belongings being returned to the resident's family."</p> <p>3. The record of Resident #125 was reviewed on 10/14/11 at 9:10 a.m.</p> <p>Resident #125 was admitted to the facility on 8/2/11 and left AMA (Against Medical Advice) on 8/9/11.</p> <p>Review of an unsigned "Inventory of</p>		<p>belongings home. The other resident was unable to be contacted for additional follow up.</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 review was completed by Social Service to identify residents that require a GDR. Once identified a GDR will be performed or documented as contra-indicted by physician or designee. Residents that discharge will have their medical record reviewed to ensure documentation of disposition personal effects.</p> <p>What measures will be put into place or what</p>		

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	<p>Personal Effects," dated 8/2/11, indicated Resident #125 brought the following items to the facility for her personal use: 1 blouse, 1 comb, 1 housecoat, 4 pieces of luggage, 3 pairs of shoes, 5 skirts, 1 pair of slippers, 9 pairs of socks, 2 sweaters and 1 afghan.</p> <p>In the box at the bottom of the inventory, there was no signature to indicate the personal items had been sent with the resident, family member or responsible party. There was no documentation in the nurses' notes to indicate the disposition of Resident #125's belongings had been addressed.</p> <p>During an interview with the Administrator on 10/14/11 at 1:10 p.m., he indicated the facility did not have an acknowledgement of Resident #125's belongings being returned to the resident or her family. He indicated he did not know what happened to them.</p> <p>3.1-50(a)(1)</p>		<p>systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Social Service, Nurse practitioner and Licensed Nurses were educated about the GDR process. Nursing staff will be in-serviced on Inventory Sheets.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>A QA audit tool will be completed by the ADNS/Designee on residents that may require a GDR to ensure completion of GDR. This will be completed weekly times four weeks and then. The results will be reviewed by QA committee monthly.</p>				

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			A QA audit tool will be completed by the ADNS/Designee on discharged charts to ensure documentation of personal effects disposition. This will be completed weekly times four weeks. The results will be reviewed by QA committee monthly. Date to be completed. 11/7/2011		