

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2015
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NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 14, 15, 16, and 17, 2015.</p> <p>Facility number: 000493 Provider number: 155728 AIM number: 100291300</p> <p>Census bed type: SNF/NF: 51 Total: 51</p> <p>Census payor type: Medicare: 6 Medicaid: 32 Other: 13 Total: 51</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents</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>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 observation, interview and record review, the facility failed to ensure a resident's dignity was maintained while dining in the dining room with assistance, related to staff speaking only with each other for 1 of 5 residents observed for dignity while dining with assistance. (Resident #47)</p> <p>Findings include:</p> <p>During an observation on 04/17/2015 at 11:57 A.M., the following was observed:</p> <p>Resident #47 was sitting in a wheel chair on the left side of the front center table. On the table in front of the resident was silverware and a napkin, no drink or food was observed. Located beside the resident was Certified Nursing Assistant (CNA) #4 and across from CNA #4 was CNA #12. CNA #4 had her back turned to the resident for 13 minutes while assisting another resident to dine.</p> <p>At 12:09 P.M., food and drinks were placed in front of Resident #47 by CNA #1.</p> <p>At 12:10 P.M., CNA #4 turned and offered Resident #47 the first spoonful of</p>	F 241	<p>1 Inservice was held on May 7th, 2015 with all staff regarding assisting residents with meal intake See attachment #1 2 All residents who require assistance to eat have the potential to be affected 3 A) All facility staff will be inserviced annually and as needed on interpersonal communications with residents while providing care and assistance B) Supervisory staff will monitor the dining room at random times daily during meals to ensure resident dignity is maintained A newly created monitoring form has been put into place to monitor behavior in Dining Room See attachment #2 4 Director of Nursing will monitor and ensure the daily monitoring is done and documented on an ongoing basis 5 Completion date: May 7, 2015</p>	05/07/2015

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	<p>food. CNA #4 was carrying on a conversation with CNA #12 throughout the meal time for Resident #47. Every few minutes, from 12:10 P.M. through 12:54 P.M., CNA #4 would turn to place food into the resident's mouth and stare at the resident while food was swallowed. After the resident had swallowed the bite size serving, CNA #4 would turn and continue the conversation with CNA #12.</p> <p>At 12:14 P.M., CNA #4 offered Resident #47 the first spoonful of thickened liquid.</p> <p>At 12:54 P.M., CNA #4 removed Resident #47's dishes, which consisted of one full glass of thickened water, an empty cup of thickened coffee and the empty food dishes, and then placed the dishes in the used dish tray.</p> <p>At 1:09 P.M. Resident #47 was transported by wheelchair from the dining room and taken to the sitting area close to the bird cage.</p> <p>During an interview on 04/17/2015 at 12:26 P.M., CNA #7 indicated staff were expected to interact with the residents and encourage the consumption of food and drink.</p> <p>Review of Resident #47's Nutritional Care Plan dated 04/07/2015, on</p>			

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	<p>04/17/2015 at 3:15 P.M., indicated Resident #47 needed assistance with eating and required honey thick liquids. The approach for Resident #47's nutritional consumption included the resident to be encouraged to socialize at meals and consume at least 75% of each meal.</p> <p>Review of the 01/09/2015 Significant Change Minimum Data Set assessment (MDS), indicated Resident #47's Brief Interview for Mental Status (BIMS) score was a 05, indicating the resident was cognitively impaired. The hearing and speech assessment of the MDS indicated Resident #47 had no difficulties in normal conversation and social interaction and also indicated the resident spoke with clear speech and understood verbal content. The Activities of Daily Living assessment indicated the resident required extensive assistance of one staff person for eating. The resident's diagnoses included, but were not limited to, recurrent urinary tract infections, weakness, and depression.</p> <p>3.1-3(t)</p>				

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F 282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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 the plan of care was followed, related to monitoring of intake and output, encouraging oral fluids and documentation of fluid intake for 1 of 2 residents reviewed of 2 residents who met the criteria for urinary catheter use. (Resident #47)</p> <p>Findings include:</p> <p>During an observation, on 04/17/2015 at 8:24 A.M., Qualified Medication Aide (QMA) #8 was assisting Resident #47 in the dining room.</p> <p>The resident's breakfast included one bowl of food and two glasses of thickened liquid. The thickened liquid consisted of one glass of orange juice and one glass of water.</p> <p>On three observations the resident reached for the spoon which was resting in the glass of thickened water. The resident tried with difficulties to raise the</p>	F 282	<p>1 Inservice was held May 7th, 2015 with all staff regarding adequate food and fluid intake and the importance of accurate documentation of the intake See attachment #3</p> <p>2 All residents have the potential to be affected</p> <p>3 All nursing staff will monitor daily at random meals to ensure accurate documentation of the meal and fluid intake using the daily monitoring form See attachment #2</p> <p>4 Director of nursing and Supervising nurses will monitor on an ongoing basis</p> <p>5 Completion date: May , 2015</p>	05/07/2015			

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	<p>spoon close enough to consume the thickened liquid as the QMA observed. The resident was only able to complete the task on one occurrence.</p> <p>At 8:49 A.M. the resident had only received two spoonfuls of thickened water when QMA # 8 removed the resident's glass and disposed of it along with the rest of the resident's dishes. The resident was observed to consume 250 ml (milliliters) during the meal time. No other liquids were observed to be consumed by the resident during the observation time. The resident was removed from the dining room at 9:02 A.M.</p> <p>During an observation, on 04/17/2015 at 11:57 A.M., Resident #47 was present in the dining room for lunch. The resident received two glasses of thickened liquid at 12:09 P.M. The empty glass of coffee and full glass of thickened water were removed at 12:54 P.M. The resident was observed to consume 240 ml of thickened liquid. No other liquids were observed to be consumed by the resident during the observation time.</p> <p>During an interview, on 04/17/2015 at 2:56 P.M., CNA#7 indicated a glass of thickened liquid contained 240 ml each. The CNA indicated residents are</p>			

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	<p>normally given three drinks with a minimum of two per meal, unless the resident was on fluid restrictions.</p> <p>Review of Resident #47's input and output chart, dated 04/17/2015, indicated QMA #8 documented the resident had consumed 360 ml at 8:49 A.M.</p> <p>Review of Resident #47's input and output chart, dated 04/17/2015, indicated CNA #12 documented the resident had consumed 240 ml of thickened liquid at 1:01 P.M.</p> <p>Record review, on 04/17/2015 at 8:15 A.M., of Resident #47's Falls Care Plan indicated the resident's interventions included, but were not limited to, staff was to advise resident in the importance of adequate fluids to maintain strength.</p> <p>Review of Resident #47's clinical record, on 04/17/2015 at 9:20 A.M., indicated the diagnoses included, but were not limited to, recurrent urinary tract infections, at risk for dehydration, and diabetes. The interventions included, but were not limited to, offer fluids between meals and snacks.</p> <p>Record review on 04/17/2015 at 3:15 P.M., of Resident #47's Nutritional Care Plan, dated 04/07/2015, indicated the</p>			

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F 315 SS=D Bldg. 00	<p>resident needed assistance with eating and required honey thick liquids. The care plan interventions included, but were not limited to, encourage the resident to consume at least 75% of each meal.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. Based on observation, record review and interview, the facility failed to ensure a resident with a supra pubic (urinary)</p>	F 315	1 Inservice was held May 7th, 2015 on assessing residents who require indwelling catheters 2 All	05/07/2015

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	<p>catheter received the necessary treatment and services to prevent infection related to the monitoring of the supra pubic catheter drainage for signs and symptoms of infection, for 1 of 2 residents reviewed for urinary catheter use of the 2 residents who met the criteria for urinary catheter use. (Resident #47)</p> <p>Findings include:</p> <p>On 04/16/2015 at 5:26 P.M., Resident #47 was observed sitting in [the resident's] room. The resident's urinary catheter collection bag had a small amount of urine which was dark, golden yellow and cloudy. The catheter collection bag and catheter tubing had visible sediment.</p> <p>During an interview on 04/16/2015 at 5:23 P.M., Certified Nursing Assistant (CNA) #13 indicated she had observed Resident #47's urine at 3:15 P.M., documented the amount of output, and reported to the nurse on duty the color and consistence.</p> <p>During an interview, on 04/16/2015 at 5:42 P.M., Registered Nurse (RN) #9 indicated she was not aware of any signs or symptoms concerning Resident #47's urine consistency and appearance. RN #9 indicated, she had not assessed Resident</p>		<p>residents who have indwelling catheters have the potential to be affected 3 A) Policy and Procedure on managing care and assessing of residents with indwelling catheters was reviewed and revised B) Resident #47 was reassessed by RN to ensure proper use of indwelling catheter, medical justification was reviewed, and updated by resident #47's physician C) An indwelling catheter assessment form has been put into place to be used on any resident admitted with a catheter, receives a new order to have a catheter placed and all current residents with catheters. The assessment form will be reviewed and if necessary updated quarterly. See attachment #4 4 Director of nursing and supervisory nurses will monitor on an ongoing basis that Policy and Procedure for catheter use is adhered to Director of nursing will inservice annually on proper resident needs assessment 5 Completion date: May 7, 2015</p>		

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	<p>47's catheter, and had planned to do the assessment soon (in the current shift).</p> <p>Review of the nursing notes on 4/17/2015 at 2:20 P.M., indicated the following:</p> <p>The nursing notes for Resident #47 were reviewed and no nursing notes were found for 04/16/2015.</p> <p>Nursing notes entered on 04/17/2015 at 4:00 A.M., indicated Resident #47's urinary catheter was intact with dark, cloudy, urine drainage found in the bed side catheter collection bag. The catheter tubing had a large amount of sediment.</p> <p>Documented on 04/17/2015 at 12:35 P.M., the preliminary urinary assessment results were received. The resident's physician and family were notified of preliminary results.</p> <p>The plan of care dated 04/07/2015, indicated the resident was at risk for recurrent urinary tract infections (UTI). The interventions included, but were not limited to, nursing and Nursing Aids (NA), to monitor resident's urine for color, frequency and consistency and NA's to notify nurse of signs and symptoms of foul smelling urine, dark urine and sediment.</p>				

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F 332 SS=E Bldg. 00	<p>Review of the 01/09/2015 Significant Change Minimum Data Set assessment (MDS), indicated Resident #47's Brief Interview for Mental Status (BIMS) score was a 05, indicating the resident was cognitively impaired. The MDS further indicated the resident needed extensive assistance with Activities of Daily Living. The resident's diagnoses included, but were not limited to, recurrent UTI's.</p> <p>3.1-41(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% was maintained for 2 of 6 residents observed during medication pass. Two errors were observed, during 28</p>	F 332	<p>1 Inservice was held on May 7th, 2015 with all nurses and QMA's regarding the administration of thyroid medications 2 All residents who are prescribed thyroid medications have the potential to be affected 3 A)</p>	05/07/2015

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	<p>opportunities for error, during medication administration. This resulted in a medication error rate of 7.1%. (Residents #64 and #8)</p> <p>Findings include:</p> <p>1. On 04/16/2015 at 8:15 A.M., Licensed Practical Nurse (LPN) #6 was observed administering 1 tablet of Synthroid 100 mcg (micrograms), to Resident #64 with morning medications including one can of Ensure and 1 tablet of ferrous gluconate.</p> <p>During an Interview, on 04/16/2015 at 12:11 P.M., LPN #6 indicated Resident #64 liked to take all morning medications at one time. The LPN indicated the resident had no reactions to Synthroid being given at the same time as other morning medications.</p> <p>The record for Resident #64 was reviewed, on 04/16/2015 at 11:15 A.M., the resident's diagnosis included, but was not limited to, hypothyroidism.</p> <p>The Physician's order, dated 02/05/2015, indicated the resident's Synthroid dose of 88 mcg was discontinued and increased to Synthroid 100 mcg to be given by mouth, on an empty stomach at 7:00 A.M.</p>		<p>Policy and Procedure for administering of Thyroid medication has been revised and reviewed by all nurse's and QMA's Resident #64 and resident # 8 dosing time for Synthroid has been adjusted to ensure it is administered before breakfast, at 6 am and only with water See attachment #5 B) All residents in the facility who are prescribed thyroid medication were reviewed and if indicated thyroid medication administration times were adjusted 4 Director of nursing and/or Assistant DON will monitor to ensure administration times for thyroid medications are before meals and with water only on an ongoing basis 5 Completion date: May 7, 2015</p>		

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	<p>The Physician's order, dated 03/17/2015, indicated the Resident was prescribed ferrous gluconate 324 mg by mouth, to be given at 9:00 A.M.</p> <p>Laboratory values reviewed for Resident #64 indicated the following:</p> <p>Collected on 02/04/2015 at 7:00 A.M., the resident's thyroid stimulating hormone serum concentration level was 14.4. The testing facility's normal thyroid stimulating hormone laboratory serum concentration level values were a range of 0.465 to 4.680.</p> <p>Collected on 03/23/2015 at 8:35 A.M., the resident's thyroid stimulating hormone serum concentration level was 0.972.</p> <p>Collected on 04/08/2015 at 6:30 A.M., the resident's thyroid stimulating hormone serum concentration level was 0.039.</p> <p>Manufacturing recommendations for the administration of Synthroid with ferrous gluconate indicated the combination may decrease the thyroid hormone efficacy.</p> <p>2. On 04/16/2015 at 8:51 A.M., Qualified Medication Aide (QMA) #8</p>			

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	<p>was administering 1 tablet of Synthroid 50 mcg to Resident #8.</p> <p>During an interview, on 04/16/2015 at 11:56 A.M., QMA #8 indicated Resident #8 had just returned from breakfast prior to receiving Synthroid. The QMA indicated the medication should have been given at 7:00 A.M. or within one hour of prescribed time and on an empty stomach.</p> <p>The record for Resident #8 was reviewed on 04/16/2015 at 11:21 A.M. The resident's diagnoses included, but was not limited to, hypothyroidism.</p> <p>The Physician's order, dated 05/14/2014, indicated the resident was to receive Synthroid 50 mcg by mouth at 7:00 A.M.</p> <p>Laboratory values reviewed for Resident #8 indicated the following:</p> <p>Collected on 05/14/2014 at 6:35 A.M., the resident's thyroid stimulating hormone serum concentration level was 2.94. The testing facility's normal thyroid stimulating hormone laboratory serum concentration level values were a range of 0.465 to 4.680.</p> <p>Collected on 08/01/2014 at 07:25 A.M., the resident's thyroid stimulating</p>			

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	<p>hormone serum concentration level was 2.34.</p> <p>The current policy and procedure for "Medication Administration", provided by the DON, on 04/17/2015 at 11:17 A.M., indicated "1. Medication will be administered within 60 minutes before or after the time ordered."</p> <p>The manufacturer recommendations for the administration of Synthroid, provided by the DON on 04/17/2015 at 11:17 A.M., indicated ..."Levothyroxine Sodium Tablets, should be taken in the morning on an empty stomach, at least one-half hour to one hour before any food is eaten. Levothyroxine Sodium Tablets, should be taken at least 4 hours apart from drugs that are known to interfere with its absorption"...1. For the administration of thyroid medications, such as levothyroxine...In the situation where a resident's serum concentration cannot be maintained within normal limits despite dose titration, the physician will schedule therapy either one hour prior to breakfast or 2 hours after dinner to increase absorption rates."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>						

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F 371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>Based on observation, interview and record review, the facility failed to prevent the ice scoop handle from touching the ice while serving drinks for 2 of 2 dining observations. This deficient practice had the potential to affect 51 residents who received drinks in the dining room.</p> <p>Findings include:</p> <p>An initial dining observation was conducted on 04/14/2015 from 11:30 A.M. to 1:00 P.M. A cart had several pitchers of beverages, an empty pitcher</p>	F 371	<p>1 Inservice was held on May 7th, 2015 for all staff regarding proper placement of the ice scoops 2 All residents who receive drinks in the facility have the potential to be affected 3 Dietary Manager purchased Ice scoop holders for all locations where ice is used and an ice scoop guardian system for the ice machine located in the kitchen The Administrator has purchased a hydration cart with a lid and canopy that will hold ice to be used during meal times 4 A) Dietary Manager and in her absence Dietary Supervisor, or charge nurses will monitor for proper use and placement of</p>	05/07/2015

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	<p>for the ice scoop, and a large bucket of ice on it. At 11:56 A.M. and at 12:47 P.M., the ice scoop was noted laying in the open bucket of ice, touching the ice. CNA (Certified Nursing Assistant) #1 and CNA #2 with their bare hands, were both observed dropping the scoop in the ice bucket during the dining observation.</p> <p>During an observation on 04/17/2015 8:17 A.M., Dietary Aide #3 with bare hands, picked up two empty glasses and walked over to the ice bucket and proceeded to fill the glasses with ice. After filling the glasses with ice, Dietary Aide #3 dropped the ice scoop into the bucket of ice with the handle lying directly on the ice. The full glasses were placed on a serving tray.</p> <p>During an observation on 04/17/2015 at 8:30 A.M., Dietary Aide #3 with bare hands, picked the scoop out of the ice bucket and filled one cup with ice. The scoop was placed into the ice bucket by Dietary Aide #3 with the handle lying directly on the ice. Dietary Aide #3 picked the scoop back out of the ice and filled a second cup with ice. After filling the second cup with ice, Dietary Aide #3 placed the scoop into the basket hanging on the side of the ice bucket.</p> <p>During an observation on 04/17/2015 at</p>		<p>equipment that is used in the kitchen, as well as dining room and areas of the building where ice is kept B) Policy and Procedure for dispensing ice and care and cleaning of the hydration cart has been revised to reflect the new equipment See attachment #6 5 Completion date: May 7, 2015</p>				

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	<p>8:37 A.M., Dietary Aide #3 with bare hands, picked up the ice scoop out of the basket on the side of the ice bucket and filled one glass with ice. After the glass was filled with ice Dietary Aide #3 dropped the scoop into the ice bucket with the handle lying flat on the ice</p> <p>During an interview on 04/17/2015 at 11:13 A.M., CNA #7 indicated when handling ice, the scoop handle should never touch the ice. After use the ice scoop should be placed into the basket on the side of the ice bucket.</p> <p>During an interview, on 04/17/2015 at 11:16 A.M., the Dietary Manager (DM) indicated the handle of an ice scoop should never directly touch the ice. The scoop should be placed into a basket or hung on the side of the ice bucket.</p> <p>The current policy and procedure for Infection Control was provided by the DON (Director of Nursing) on 04/16/2015 at 2:30 P.M. Item 16 of the "General Instructions for Supplies/Equipment", indicated ice scoops and containers are disinfected daily by Dietary Services. Ice coolers are washed with disinfectant solution, rinsed and air dried on a daily basis.</p> <p>3.1-21(i)(2)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-21(i)(3)				