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
	155247		04/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	8549 S MADISON AVE INDIANAPOLIS, IN 46227

(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. This visit included the Investigation of Complaints IN00195939 and IN00195843. Complaint IN00195939 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00195843 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: March 28, 29, 30, 31, April 1, and 4, 2016. Facility number: 000151 Provider number:155247 AIM number: 100284060 Census bed type: SNF: 23 SNF/NF:79 Total: 102 Census payor type: Medicare: 10 Medicaid: 44 Other: 48 Total: 102	F 0000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain incompliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Q.R. completed by 14466 on April 08, 2016.			
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a			

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	material and false statement. Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected the medications a resident received for 1 of 5 residents who met the criteria for review of medications. (Resident #72) Findings include: The clinical record review for Resident #72 was completed on 3/30/2016 at 10:58 a.m. Diagnoses included, but were not limited to, edema and hypertension. A MDS assessment dated 2/22/2016, indicated Resident #72 did not receive a diuretic medication between 2/16/2016 and 2/22/2016. This MDS was signed by RN #1, verifying accuracy of assessment. A review of the Medication Administration Record (MAR) (the documentation used for the medication assessment on the 2/22/2016 MDS), indicated Resident #72 received Lasix (a medication that promotes the production of urine / a diuretic) on February 16, 17, 18, 19, 20, 21, and 22, 2016. On 4/01/2016 at 2:30 p.m., the MDS Coordinator indicated Resident #72 did receive a diuretic medication on	F 0278	**F278 AssessmentAccuracy/Coordination/Certified** Itis the practice of this facility to comply with F278 to ensure the assessmentaccurately reflects the resident's status. **What corrective actions(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Resident#72's MDS has been updated to accurately reflect the resident's current status. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken?** - Allresidents have the potential to be affected by this finding. - Thecenter will review the most recent MDS for the residents who reside in thisfacility to ensure that their MDS has been coded accurately to reflect theircurrent status. Discrepancies found will be updated to the MDS so that itaccurately reflects the current status of the resident.	05/04/2016

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	February 16, 17, 18, 19, 20, 21, and 22, 2016. He indicated the MDS dated 2/22/2016, section N, was coded incorrectly. 3.1-31(g)		**What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** MDSpersonnel have been in serviced to ensure the MDSs are being coded accuratelyto reflect the current status of the residents. TheMDS Coordinator will audit 15 MDSs, using an audit tool, each week for eightweeks to ensure that the MDSs are being coded correctly to ensure they reflectthe current status of the resident. Discrepancies found will be updated to theMDS so that it accurately reflects the current status of the resident. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put in place?** Resultsof the audits will be reviewed for patterns/trends weekly by Administrator/AdministrativeDirector of Nursing Services. Any non-compliance identified will be addressedwith a Plan of Action to be reviewed weekly by the Administrator/designee untilcompliance is achieved.	

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			QualityAssessment and Assurance Committee will review for ongoing compliance andaccept and/or make recommendation monthly ongoing. - **By what date the systemicchanges will be completed?** - May 4,2016	
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. Resident #51 Based on record review and interview,	F 0329	**F329 Drug Regimen is free fromUnnecessary Drugs**	05/04/2016

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	the facility failed to ensure the cause of a resident's insomnia was evaluated and alternative interventions were considered prior to the administration of a medication used to aid in inducing sleep, for 1 of 5 residents who met the criteria for review of unnecessary medication use. (Resident #51) Findings include: The clinical record review for Resident #51 was completed on 3/30/2016 at 3:45 p.m. Diagnoses included, but were not limited to, insomnia and anxiety. A recapitulated physician's order for March, 2016, with an original date of 2/3/2016, indicated Resident #51 could receive Trazodone, 50 mg, every night as needed, for insomnia. Trazodone is a medication with sleep-inducing effects. Medication Administration Records for March, 2016, indicated the resident received Trazodone on 3/2/2016 at 10:46 p.m., 3/21/2016 at 10:13 p.m., and 3/27/2016 at 9:24 p.m. No documentation was found in the resident's clinical record which indicated the cause of her insomnia had been evaluated or alternative interventions had been considered prior to administration		Itis the practice of this facility to comply with F329 to ensure each resident'sdrug regimen is free from unnecessary drugs. **What corrective actions(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Resident#51 did not experience any adverse effect as a result of receiving PRNTrazadone for insomnia. Resident#51 receives Hospice Services and has a BIMs score of "14". This resident isbeing offered alternative interventions such as repositioning, food/fluids,change in room temperature and room lighting. These interventions are beingoffered prior to utilizing the PRN Trazadone with refusals documented. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken?** Residentswith a PRN order for insomnia could be affected; however no other resident hasbeen affected by this finding. Anaudit has been completed of all medication orders to determine which residentshave PRN	

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	of the Trazodone. On 4/4/2016 at 3:13 p.m., the Director of Nursing (DON) indicated she was not able to find any alternative interventions attempted on March 2, 21, or 27, 2016, when the Trazodone was administered. On 4/4/2016 at 3:40 p.m., the DON indicated there was no policy found relating to pro re nata (PRN or as needed) medications and prior interventions. 3.1-48(a)(4)		medications for insomnia. Residents identified with PRN orders forinsomnia have had an assessment and progress note completed by thephysician/physician extender to address the cause of the insomnia. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** Licensednurses have been in serviced regarding documentation of alternativeinterventions offered and/or implemented prior to PRN medicationadministration. Directorsof Care Delivery will audit new PRN psychoactive medication orders as they arereceived to ensure the medication is appropriate to the diagnosis and need. Auditswill also be completed weekly for four weeks and then monthly for documentationof physician progress notes to address the use of PRN psychoactive medicationand of alternative interventions. Lack of documentation will be reported to theAdministrative Director of Nursing Services and will be addressedappropriately.	

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			How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put in place? - Resultsof the audits will be reviewed for patterns/trends weekly byAdministrator/ADNS. Any non-complianceidentified will be addressed with a Plan of Action to be reviewed weekly by theAdministrator/designee until compliance is achieved. QualityAssessment and Assurance Committee will review for ongoing compliance andaccept and/or make recommendation monthly ongoing. - **By what date the systemicchanges will be completed?** - May 4,2016	
F 0412 SS=D Bldg. 00	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged			

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	dentures to a dentist. Based on interview and record review, the facility failed to ensure a follow-up dental appointment was scheduled for a resident with tooth pain complaints (Resident #134). Findings include: A clinical record review was completed on 03/31/2016 at 11:42 a.m., for Resident 134. Diagnosis included, but were not limited to, status post CVA (cerebrovascular accident/stroke). A dental clinical record review indicated on 3/9/16, Resident #134 was seen by the contracted dentist for the facility with an indicated assessment result of, "pt [patient] partially edentulous and complaining of problems with #25 [tooth number]; attempts to debride/evaluate more closely responses with painful reaction; Treatment: oral exam, debride; Recommendations: office visit, x-ray, evaluate and treat #25, others." During an interview with Resident #134 on 03/29/2016 at 11:05 a.m., the resident indicated his teeth hurt and he had spoken with the doctor and social worker about this, but nothing had been done to address the issue.	F 0412	**F412 Routine/Emergency DentalServices in NFS** Itis the practice of this facility to comply with F412 to provide or obtain froman outside resource, in accordance with 483.75(h) of this part, routine (to theextent covered under the State plan); and emergency dental services to meet theneeds of each resident; must, if necessary, assist the resident in makingappointments; and by arranging for transportation to and from the dentist'soffice; and must promptly refer residents with lost or damaged dentures to adentist. **What corrective actions(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Resident#134 did not experience any adverse effects as a result of not having hisfollow up dental appointment made. Resident#134 had a follow up dental appointment for 4/11/16 and he refused to go.Another appointment was made for 4/19/16 and he refused again. He now has anappointment for 4/26/16. **How other residents having thepotential to be affected by the same deficient practice will**	05/04/2016

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	During an interview on 04/01/2016 at 2:02 p.m., the facility Social Services Director (SSD) indicated there is no written facility policy or procedure regarding resident dental care appointments. The SSD indicated that after the contracted dentist conducts an exam the SSD reviews the dental notes and ensures recommended follow-up appointments are made via telephone contact with the dentist office within one to two weeks. The SSD indicated being somewhat certain she had reviewed the dental note of 3/9/2016, and confirmed that no follow-up appointment had yet been scheduled for Resident #134. 3.1-24(b)		**be identified andwhat corrective action(s) will be taken?** Residentsresiding in the facility thatexperience tooth/mouth pain have the potential to be affected by this finding.The facility audited the residents and none of the other residents wereaffected. SocialServices will review all notes received from the dentist in the past 60 days tomake sure that any recommendations for follow up have been scheduled. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** SocialService personnel have been in-serviced regarding timely follow up to dentalrecommendations. SocialServices will review dental recommendations within 24 hrs. of receivingthem. Any recommended follow up will be scheduled within 72 hrs. of thereview. An auditwill be completed weekly by the Social Service Director/designee for four weeksand then monthly to ensure residents with dental	

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			appointments have theappropriate follow up necessary. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put in place?** - Resultsof the audits will be reviewed for patterns/trends weekly by Administrator/designee. Any non-compliance identified will beaddressed with a Plan of Action to be reviewed weekly by theAdministrator/designee until compliance is achieved. QualityAssessment and Assurance Committee will review for ongoing compliance andaccept and/or make recommendation monthly ongoing. - **By what date the systemicchanges will be completed?** - May 4,2016	
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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			

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	and infection. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on record review and interview, the facility lacked documentation of a screening for tuberculosis for each employee prior to employment and annually thereafter for 3 of 10 employee files reviewed. (employees #7,#15, #150) Findings Include:	F 0441	**F441 Infection Control, PreventSpread, Linens** Itis the practice of this facility to comply with F441 to establish and maintainan Infection Control Program designed to provide a safe, sanitary andcomfortable environment and to help prevent the development and	05/04/2016

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	Employee files were reviewed on 4/01/16 at 10:00 a.m., with the following findings: 1. Employee #7 Date of hire 02/24/2016 Title: Certified Nurse Aide. Lacked documentation of screening for tuberculosis. 2. Employee #15 Date of hire 12/24/2015 Title: Dietary Aide. Lacked documentation of screening for tuberculosis. 3. Employee #151 Date of hire 05/13/2013 Title: License Practical Nurse. There was no documentation of annual screening for tuberculosis. Human Resource Director was interviewed on 4/6/2016 at 1:30 p.m., and indicated he had provided all documentation for screening for tuberculosis. He was unable to find any further documentation. The above mentioned nursing staff had not received the required screening for tuberculosis. 3.1-14(t)(1)		transmission ofdisease and infection. **What corrective actions(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Noresidents were affected by this finding. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken?** Residentsresiding in the facility have the potential to be affected by this finding. Employees#7, #15 and #151 now have the appropriate documentation for screening oftuberculosis. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** HumanResources Director has been in-serviced regarding the appropriate documentationfor screening each employee for tuberculosis prior to employment	

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			and annuallythereafter. Anaudit was performed to ensure that other employees have the appropriatedocumentation for tuberculosis screening in their personnel file. Discrepanciesfound have been updated. Anaudit will be completed weekly by the Infection Control Nurse/designee for fourweeks and then monthly to ensure employees have the appropriate documentationfor screening for tuberculosis prior to employment and annually thereafter. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put in place?** Resultsof the audits will be reviewed for patterns/trends weekly byAdministrator/designee. Anynon-compliance identified will be addressed with a Plan of Action to bereviewed weekly by the Administrator/designee until compliance is achieved. QualityAssessment and Assurance Committee will review for ongoing compliance andaccept and/or make recommendation monthly ongoing.	

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			- **By what date the systemicchanges will be completed?** - May 4,2016	