

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 09/12/2014
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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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F000000	<p>This visit was for the Investigation of Complaints IN00155219, IN00155243, and IN00155603.</p> <p>Complaint IN00155219 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00155243 - Substantiated. Federal/State findings related to the allegations are cited at F157 and F159.</p> <p>Complaint IN00155603 - Substantiated. Federal/State findings related to the allegations are cited at F315, F279, and F514.</p> <p>Survey dates: September 8, 9, 10, and 12, 2014</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 125 SNF: 23 Total: 148</p> <p>Census payor type:</p>	F000000	<p>September 29, 2014 Long Term Care Division, 4th Floor 2 North Meridian Street Indianapolis, IN 46204 RE: ManorCareHealth Services of Anderson 1345 N. Madison Ave. Anderson, IN 46011 Dear Kim Rhoades: Please note our Plan of Correction for the Complaint Survey completed on September 12, 2014. Our date of alleged compliance is October 12, 2014. We respectfully request a desk review. Should you have any other questions or need additional information, please contact me at 765.644.2888. You may also contact me via email at 421admin@hcr-manorcare.com. Sincerely, Nicole Fields, HFA Administrator</p>	
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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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F000157 SS=D	<p>Medicare: 19 Medicaid: 106 Other: 23 Total: 148</p> <p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in</p>						

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	<p>§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure a resident's guardian was notified of a change in Medicare coverage for 1 of 1 resident with a guardian who approached an alternate Medicare provider and changed her Medicare coverage in a sample of 5. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 9/8/14 at 3:15 p.m. Diagnoses for the resident included, but were not limited to, bipolar disorder, schizo-affective disorder, kidney disease, and diabetes mellitus.</p> <p>The clinical record indicated Resident #D had a legal guardian. The legal guardian was also listed as her first emergency contact and the person to whom the customer satisfaction survey was to be sent.</p> <p>The clinical record indicated Resident #D had an increase in her manic behaviors in</p>	F000157	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The guardian for resident D is aware of change in Medicare coverage for resident D. The facility assisted the guardian with cancellation of the Medicare Replacement Policy and resumption of traditional Medicare coverage.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents eligible for Medicare benefits and have a legal guardian or durable power of attorney have the potential to be affected by this same deficient practice.</p> <p>Residents with Medicare benefits will be reviewed to ensure their business record reflects the appropriate party to be notified if the resident is interested in considering a Medicare Replacement Policy.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p>	10/12/2014			

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	<p>July 2014 and was hospitalized in a behavioral health hospital from 7/9/14 through 7/23/14. The clinical record indicated the resident had both Medicare and Medicaid coverage.</p> <p>The resident's clinical record contained a document that indicated:</p> <p>"Stop</p> <p>Optum Care Plus Resident</p> <ol style="list-style-type: none"> 1. Notify the Optum CarePlus Nurse Practitioner of ANY changes in the resident's condition!! 2. Remind the MD [medical doctor] that the resident is an Optum CarePlus resident if you are consulting the MD by phone!! 3. DO NOT write ANY orders for therapy, including evaluations without prior approval from the Optum CarePlus Nurse Practitioner!!" <p>The Business Office Manager was interviewed on 9/10/14 at 2:05 p.m. She indicated the resident had signed herself up for a Medicare Advantage program when an agent from the company had visited the building. She provided an "Eligibility Response" form that</p>		<p>Business Office, Social Service, and Optum staff assigned tour facility will be educated on the process to present Medicare ReplacementPolicies to eligible residents, POAs and legal guardians. Audit tool will be completed by the BOM/designee validatingthe appropriate notification of change in a resident's Medicare benefits. Please see attachment A.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur;i.e., what quality assurance program will be put into place;</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&A committee will review findings and determineneed for further monitoring and/or education per the QA&A process.</p>				

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	<p>indicated the resident had been covered by the alternate Medicare provider from 7/1/14 through 8/31/14.</p> <p>The resident's legal guardian was interviewed on 9/10/14 at 11:30 a.m. She indicated the facility had not notified her of the change in the resident's Medicare provider. She indicated the resident should not have been able to make this change due to her mental status. She indicated she had no knowledge of the change until an agent from the Medicare Advantage program had called her in late August. She indicated she was very unhappy with the change and had signed a coverage cancellation letter on 8/28/14.</p> <p>The DON (Director of Nursing) was interviewed on 9/10/14 at 2:10 p.m. She indicated Resident #D had overheard the Medicare Advantage agent explaining the program when he was meeting with another facility resident and Resident #D had signed herself up for the change in Medicare providers. The DON indicated the facility had not notified the resident's legal guardian of the change when they became aware of the Medicare provider change.</p> <p>This federal tag relates to Complaint IN00155243.</p>			

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F000159 SS=D	<p>3.1-5(a)(2)</p> <p>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.</p> <p>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.)</p> <p>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.</p> <p>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.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal</p>			

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	<p>representative.</p> <p>The facility must notify each resident that 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.</p> <p>Based on record review and interview, the facility failed to ensure resident fund statements were sent quarterly to the resident's responsible party for 2 of 3 residents reviewed with facility managed resident fund accounts in a sample of 5. (Resident #D and #E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #D was reviewed on 9/8/14 at 3:15 p.m. Diagnoses for the resident included, but were not limited to, bipolar disorder, schizo-affective disorder, kidney disease, and diabetes mellitus.</p> <p>The clinical record indicated Resident #D had a legal guardian. The legal guardian was also listed as her first emergency contact and the person to whom the customer satisfaction survey was to be sent. The clinical record indicated the resident had resided in the building for</p>	F000159	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The business record for Resident D was reviewed and updated to ensure quarterly Resident Trust Fund Statement is sent to the resident D's legal guardian. The business record for Resident E was reviewed and updated to ensure quarterly Resident Trust Fund Statement is sent to the resident E's durable power of attorney. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; Residents with resident trust accounts and a legal guardian or durable power of attorney have the potential to be affected by this same deficient practice. Residents with a resident trust account will be reviewed to ensure their business record reflects the appropriate party to receive the quarterly</p>	10/12/2014			

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	<p>more than a year.</p> <p>The resident's legal guardian was interviewed on 9/10/14 at 11:30 a.m. She indicated Resident #D had a resident fund account managed by the facility since the resident's admission. She indicated the facility had sent her at least one quarterly resident fund statement, but she had not received any others for a long period of time.</p> <p>The Business Office Manager (BOM) and the DON (Director of Nursing) were interviewed on 9/10/14 at 2:05 p.m. Additional information was requested related to the lack of quarterly statements having been sent to the legal guardian of Resident #D. The BOM indicated Resident #D did have a resident fund account and she would check and see to whom the quarterly statements were being sent.</p> <p>The BOM was interviewed on 9/10/14 at 3 p.m. She indicated she had been sending statements to the resident. She indicated she was unaware the resident had a legal guardian until 7/9/14. She indicated the July 2014 statements had already been sent at that time. She indicated she had changed her records and the resident's legal guardian would now receive future quarterly statements.</p>		<p>resident trust fund statement.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur; Business Office and Social Service staff will be educated on the resident trust fund requirements. Audit tool will be completed by the BOM/designee validating the appropriate recipient of the quarterly resident trust fund statement in noted on the resident's account. Please see attachment B. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place; Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>				

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	<p>2. The clinical record for Resident #E was reviewed on 9/8/14 at 2:10 p.m. Diagnoses for the resident included, but were not limited to, cognitive communication deficit, chronic kidney disease, diabetes mellitus, and depression.</p> <p>The clinical record indicated Resident #E had a family member who was her health care representative and durable power of attorney.</p> <p>The Business Office Manager (BOM) and the DON (Director of Nursing) were interviewed on 9/10/14 at 2:05 p.m. The BOM indicated Resident #E had a resident fund account with the facility. She indicated quarterly statements were sent to the resident because she had no guardian or power of attorney. Additional information was requested related to the clinical record documenting a family member as the resident's durable power of attorney. The BOM indicated she would check the resident's record for this information.</p> <p>The BOM was interviewed on 9/10/14 at 3:05 p.m. She indicated she had checked and the resident did have a family member who was her power of attorney. She indicated she had changed her</p>			

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F000279 SS=D	<p>records and future quarterly statements would be sent to this family member.</p> <p>This federal tag relates to Complaint IN00155243.</p> <p>3.1-6(g)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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).</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive health care plan was developed for 1 of 3 residents reviewed with an indwelling Foley catheter in a sample of 5. (Resident #C)</p>	F000279	<p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice;</p> <p>Clinical record for resident C was reviewed and the</p>	10/12/2014

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	<p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 9/8/14 at 11:15 a.m. Diagnoses for the resident included, but were not limited to, intracerebral hemorrhage, neurogenic bladder, and Alzheimer's dementia.</p> <p>An admission Minimum Data Set assessment, dated 8/18/14, indicated Resident #C was mildly cognitively impaired and required extensive assistance from the staff for all activities of daily living.</p> <p>A health care plan problem, dated 8/11/14, indicated the resident had an anchored catheter in place due to a neurogenic bladder. The only intervention for this problem was "Evaluate for any possible contributing factors for use of catheter such as pain, skin problems, medications, underlying medical condition, etc."</p> <p>The health care plan lacked any information related to the monitoring of the resident's urine for signs and symptoms of infection, monitoring of the catheter for patency, and/or how often catheter care was to be provided to help prevent infection.</p>		<p>comprehensivehealth care plan has been revised and updated to reflect assessment and careneeds with focus on catheter care.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken;</p> <p>Residents with foley catheters have the potential to beaffected by this same deficient practice. Residents with indwelling cathetershave been reviewed to ensure their clinical record and comprehensive care planreflect assessments and care needs with focus on catheter care.</p> <p>What measures will beput into place or what systemic changes will be made to ensure that the samedeficient practice does not recur;</p> <p>Licensed nurses have been provided education and a return demonstrationcheck-off on preparation of health care plans and the facility guidelines forcare plan development.</p> <p>Audit tools will be completed by the ADNS/designee regardingaccurate completion of comprehensive care plans for residents with indwellingcatheters, review of comprehensive care plans, and revisions of care plans asneeded. Please see attachment C.</p>		

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	<p>The Social Services provider for the Rehab Hall was interviewed on 9/10/14 at 10:40 a.m. She indicated Resident #C had a history of delaying care by saying "come back later" or "wait till my sister is here". The clinical record lacked any health care planning relating to the resident refusing or delaying care. When queried regarding the lack of a health care plan for refusals of care, the Social Services provider for the Rehab Hall checked the computerized clinical record and indicated there was no health care plan in place for refusals/delays of care.</p> <p>The DON (Director of Nursing) and Administrator were interviewed on 9/10/14 at 2:20 p.m. Additional information was requested related to the lack of a comprehensive health care plan having been developed related to the resident's indwelling catheter use and history of refusals and/or delays in the provision of care.</p> <p>The DON was interviewed on 9/12/14 at 10:55 a.m. She indicated the resident's health care plan for the need for an indwelling catheter had now been updated and was more comprehensive.</p> <p>This federal tag relates to Complaint IN00155603.</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>	
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F000315 SS=D	<p>3.1-35(a) 3.1-35(b)(1)</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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure daily catheter care was provided for 2 of 3 residents reviewed for catheter care in a sample of 5. (Resident #F and #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #F was reviewed on 9/9/14 at 9:30 a.m. Diagnoses for the resident included, but were not limited to, multiple sclerosis, bipolar disorder, diabetes mellitus, and pressure ulcer lower back (sacral area). The clinical record indicated the resident had a Foley catheter ordered on 8/21/14</p>	F000315	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident C is receiving catheter care per facility guidelines.</p> <p>Resident D is receiving catheter care per facility guidelines.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents with indwelling catheters have the potential to be affected by the same deficient practice. A</p>	10/12/2014

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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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	<p>to assist in healing of the sacral pressure ulcer.</p> <p>A quarterly Minimum Data Set assessment, dated 6/30/14, indicated Resident #F was severely cognitively impaired and required extensive assistance from the staff for all activities of daily living.</p> <p>A health care plan problem, last reviewed and updated on 7/28/14, indicated the resident had a problem with bowel incontinence related to impaired mobility and cognitive deficit. One of the interventions for this problem included, "Check for bowel incontinence frequently and provide incontinent care prn [as needed]."</p> <p>During observation of a dressing change to the resident's sacral area on 9/9/14 at 11:05 a.m., the following was noted:</p> <p>LPN #1 and RN #2 entered the resident's room to complete a dressing change on the resident's sacral pressure area. The resident was lying on her back in bed. After all the pre treatment preparations were completed, the resident was turned to her side and her brief was unattached to allow access to the sacral area. The resident had been incontinent of a loose yellowish/brownish bowel movement</p>		<p>clinical record review was completed to identify residents having the potential to be affected by the same deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</p> <p>Licensed nurses and Certified Nursing Assistants have been provided education and return demonstration check-off on the proper completion of catheter care per the facility guidelines.</p> <p>Audit tools will be completed by the ADNS/designee regarding observation of catheter care for accurate completion of care per facility guidelines. This review will include a minimum of 5 observations per week. Please see attachment D.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>				

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	<p>which had absorbed into the inside of the brief. The outer brief was tucked over to cover the soiled section of the brief. The dressing change was completed as ordered which included cleansing of the wound.</p> <p>Following completion of the dressing change, LPN #2 provided incontinent care to the resident's rectal and buttock area. The resident had a small amount of soilage with each cleansing cloth used. When the resident's rectal area was clean the resident was turned to her back. A new brief was placed under the resident and LPN #1 and RN #2 began to close both side of the resident's brief.</p> <p>When queried about catheter care for Resident #F related to having been incontinent of bowel, LPN #1 indicated she would provide it. LPN #1 opened the front of the brief and used additional cleansing wipes to provide front peri care and catheter care for Resident #F.</p> <p>The DON (Director of Nursing) was interviewed on 9/10/14 at 2:20 p.m. Additional information was requested related to the lack of catheter/incontinent care having been provided for Resident #F during the described observation until a query was made.</p>			

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	<p>RN #2 was interviewed on 9/12/14 at 11:20 a.m. She indicated LPN #1 had not completed catheter care to Resident #F as noted previously because she did not think the resident had finished having the bowel movement and she was going to have the aides check her later.</p> <p>2. The clinical record for Resident #C was reviewed on 9/8/14 at 11:15 a.m. Diagnoses for the resident included, but were not limited to, intracerebral hemorrhage, neurogenic bladder, and Alzheimer's dementia.</p> <p>An admission Minimum Data Set assessment, dated 8/18/14, indicated Resident #C was mildly cognitively impaired and required extensive assistance from the staff for all activities of daily living.</p> <p>A health care plan problem, dated 8/11/14, indicated the resident had an anchored catheter in place due to a neurogenic bladder. The only intervention for this problem was "Evaluate for any possible contributing factors for use of catheter such as pain, skin problems, medications, underlying medical condition, etc."</p> <p>A Nurse Practitioner (NP) note, dated 8/28/14 at 12:56 p.m., indicated she had</p>			

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	<p>been asked to see the resident due to an unresponsive episode. The note indicated the nurses had reported that the resident's catheter bag had been full of cloudy urine. Following the examination by the NP, an order was received for the resident to be sent to the emergency room for evaluation and treatment. The clinical record did not indicate the time the resident was dismissed to the hospital.</p> <p>Review of an "Emergency Department Record", dated 8/28/14, contained the following entry completed by Emergency Room (ER) Nurse #3, dated 8/28/14 at 1:45 p.m.. "...Pt [patient] is noted to have indwelling Foley catheter in that has purulent urine. Urine has pus and amber particles floating in catheter bag and Foley is dried to penis and no leg attachment is noted in place. There is dried stool between pt's legs and underside of pt's testicles...." The report indicated the resident was admitted to the hospital for treatment of a urinary tract infection.</p> <p>ER Nurse #3 was interviewed on 9/9/14 at 9:30 p.m. She indicated Resident #C did have dried feces between his legs and on his scrotum and buttocks when he was evaluated in the ER on 8/28/14. She indicated the feces was dried and</p>			

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	<p>appeared to have been there for hours. She indicated her main concern was the status of the resident's urine and catheter tubing. She indicated the urine in the bag was very purulent in appearance which could be easily noted. She indicated the catheter was soiled with lots of dried secretions and the catheter was stuck to the resident's penis. She indicated it did not appear that the resident had received any catheter care for a long time, even days. ER Nurse #3 indicated she changed the catheter while the resident was in the emergency room due to the condition of the catheter, tubing, and urinary drainage bag.</p> <p>The DON (Director of Nursing) and Administrator were interviewed on 9/10/14 at 2:20 p.m. Additional Information was requested related to the resident's condition at the time of transfer to the hospital on 8/28/14. The facility failed to provide any additional information related to this concern as of exit on 9/12/14.</p> <p>3. Review of the current facility policy, dated 11/2011, titled "Catheter Care: Indwelling Catheter", provided by the DON on 9/10/14 at 11:05 a.m., included, but was not limited to, the following:</p> <p>"Purpose: To recommend the steps of</p>			

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	<p>catheter care hygiene for patients with indwelling catheters....</p> <p>10. Examine genitalia for signs of inflammation, skin breakdown or discharge and ask patient if burning or discomfort is felt. Report unusual findings to nurse and, or physician as clinically indicated.</p> <p>11. Provide perineal care</p> <p>Female: Gently separate labia and wash area around catheter insertion site using downward strokes from pubic to rectal area....</p> <p>Male: ...Wash area wound catheter insertion site, from meatus outwards and then wash from tip of penis down to body including scrotum and skin folds...</p> <p>Suggested Documentation: Care provided and reaction to procedure, size of catheter and balloon. Unusual observations, color and amount of urine and/or complaints and subsequent interventions including communications with physicians."</p> <p>This federal tag relates to Complaint IN00155603.</p>			

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F000514 SS=D	<p>3.1-41(a)(1)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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. Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented in regards to food consumption for 1 of 1 resident reviewed with a G-tube in a sample of 5.</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 9/8/14 at 11:15 a.m. Diagnoses for the resident included, but were not limited to, intracerebral hemorrhage, neurogenic bladder, and Alzheimer's dementia.</p>	F000514	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Clinical Record for resident C was reviewed and updated to reflect his NPO status. Staff interviews completed to validate resident C did not consume food.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents who reside in the facility</p>	10/12/2014

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	<p>The clinical record indicated the resident had been NPO (unable to receive any food/liquids by mouth) since admission. The clinical record also indicated the resident received all nutritional needs via gastrostomy tube feedings.</p> <p>Computerized meal consumption records for Resident #C, dated from 8/12/14 through 9/8/14, indicated the resident had consumed 100% of his meal on 14 occasions during that time. The records indicated the resident consumed 50% of his meal on 3 occasions during this time period. The other days were designated as either not available or not applicable.</p> <p>The DON (Director of Nursing) and Administrator were interviewed on 9/10/14 at 2:20 p.m. related to the documentation of meal intake for the Resident C when he did not receive a meal tray due to being "NPO".</p> <p>The DON was interviewed on 9/12/14 at 10:55 a.m. She indicated statements had been obtained from all the CNAs who documented meal intake on the dates. She indicated the entries had been in error and no food or fluid had been given to the resident.</p> <p>This federal tag relates to Complaint</p>		<p>and are NPO have the potential to be affected by this deficient practice. Residents that are NPO had their clinical record reviewed and validated to ensure resident specific documentation is free from error in documentation related to food consumption.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Nurses have been educated on the required documentation when a resident is NPO, which includes removing the prompt on electronic documentation to prevent incident of incorrect charting.</p> <p>C.N.A.'s have been educated on the role of the C.N.A. and clinical record documentation.</p> <p>The DCD/designee will monitor the residents that are NPO weekly to ensure their food consumption records are accurate. Please see attachment E.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter.</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

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	IN00155603. 3.1-50(a)(1) 3.1-50(a)(2)		Ongoing monitoring will continue for a minimum of six months. QA&A committee will review findings and determine if further monitoring and/or education per the QA&A process.		