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 12/23/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00141184. This visit was in conjunction with the Recertification and State Licensure Survey. Complaint IN 00141184 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: December 16, 17, 18, 19, 20 and 23, 2013. Facility number: 000005 Provider number: 155005 AIM number: 100270840 Survey team: Tina Smith-Staats, RN TC Karen Lewis, RN (December 16,17,18,19 and 23, 2013) Toni Maley, BSW Karen Koeberlein, RN (December 16,17,18,19, 20, 2013) Census bed type: SNF: 27 SNF/NF: 126 Total: 153 Census payor type:	F000000	February 6, 2014 Long Term Care Division, 4th Floor2 North Meridian StreetIndianapolis, IN 46204 RE: ManorCare Health Services of Anderson 1345 N. Madison Ave. Anderson, IN 46011 Dear Kim Rhoades: Please note our Plan of Correction for the Recertification and State Licensure Survey in conjunction with Complaint # IN00141184 completed on December 23, 2013. Our date of alleged compliance is January 22, 2014. We respectfully request a desk review. Should you have 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, HFAAdministrator	

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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	Medicare: 20 Medicaid: 104 Other: 29 Total: 153 Sample: 8 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, and interview, the facility failed to ensure wheel chair brakes were locked during resident care and gait belts were used during ambulation for 2 of 4 residents reviewed for resident care safety. (Resident #A and #B)	F000323	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident A no longer resides at the facility. Clinical record for resident B has been reviewed and updated to reflect current ambulation needs and fall risk interventions. How other	01/22/2014

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	Findings include: 1.) The clinical record for Resident #A was reviewed on 12/19/13 at 9:00 a.m. Diagnoses included but were not limited to hypertension, seizure disorder, depression, gastric esophageal reflux, dementia, Alzheimer ' s, congestive heart failure, right ankle fracture, atrial fibrillation. An Incident Report, dated 11/15/13, indicated "Resident was walking back from DR (sic) with CNA and rolling walker when his legs 'just gave out'. VSS(vital signs stable), resident denies injury or pain. VS and resident assessed for injury, assisted into wheelchair and into recliner in room." Statement from a witness of the fall, dated 11/15/13, indicated "After dinner I was walking [Resident #A] down the hall and right before we got to his room his legs gave out and I held him as long as I could before I sat him down on the floor." CNA #1. Care Plan, dated 9/28/13, and revised 11/18/13, indicated a focus of "At risk for falls due to history of		residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; Patients who require assist with transfers/mobility have the potential to be affected. Clinical record review was completed to ensure appropriate interventions are in place and available for staff to review prior to providing care to the residents. Please see Attachment E. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur; Clinical staff will be educated by the Administrative Director of Nursing or Director of Care Delivery/Administrative Nurses on the use of mobility devices, transfers and safety with mobility. Please see Attachment F. Each new admission or patients with a change in mobility status will be reviewed during daily QAA meetings to validate that care plans and Kardex reflect the patient's individual needs and/or assistive devices to maintain their safety. Review and revision will occur as needed based on patient's individual needs. The Director of Care Delivery or designee will conduct a minimum of eight observations daily five times per week to include all shifts and weekends to ensure staff are following interventions for staff transfer and ambulation of residents that require	

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	falls with interventions of: "Bed in low position, Encourage rest periods when ambulating. Have commonly used articles within easy reach. Provide assist to transfer and ambulate as needed. Staff assists during ambulation. Therapy screen change for change in rolling walker to a walker with a seat. Nurses notes, dated 11/15/13 at 2037 (8:37 p.m.), indicated the resident was ambulating back to his room from the dining room and was assisted to the floor by a CNA. The physician and daughter were notified. Electronic Medical Record Task Sheet indicated "Fall risk assist when ambulation/ encourage use of rest periods when ambulating use gaitbelt (sic), use walker during ambulation." During an interview, on 12/23/13 at 9:50 a.m., with the Director of Nursing (DoN), the DoN indicated the term physical assist included the use of gait belts with ambulation. During an interview with CNA #1, the CNA stated she did not offer the resident a gait belt, while assisting the resident to ambulate him from		supervision, assistance and or use of devices for mobility. Any concerns that are discovered during these reviews will be addressed immediately. Please see attachment G. 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 the QA&A Committee weekly for 4 weeks and monthly thereafter for a minimum of 6 months. The QA&A Committee will review findings and determine the need for further monitoring and/or education per the QA&A process.	

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	the dining room, prior to his fall. She further indicated she should have used a gait belt to assist with ambulation. Lewis, Karen 2. The clinical record for Resident #B was reviewed on 12/18/13 at 1:04 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's dementia, depression, hypertension, and congestive heart failure. A quarterly Minimum Data Set assessment, dated 10/7/13, indicated the resident was moderately cognitively impaired and required extensive assistance with 1 member of the staff for dressing, personal hygiene and toileting. Review of the incident report for the 10/30/13 fall indicated the resident had been assisted from the bathroom to a wheelchair using a walker by CNA #5. The brakes on the wheelchair were not locked. The wheelchair moved as the resident sat down resulting in the resident being lowered to the floor. The incident report lacked any documentation of CNA #5 having used a gait belt while assisting the resident.			

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	Review of the incident report for the 11/23/13 fall indicated the resident had been assisted to the bathroom. The resident lost her balance as CNA #4 was assisting the resident with her brief. The incident report lacked any documentation of CNA #4 having used a gait belt while assisting the resident. During an interview with the Director of Nursing on 12/23/13 at 9:00 a.m., she indicated the brakes on the wheelchair should have been locked before having Resident #B sit down. She further indicated a gait belt should have been used while assisting the Resident #B. During an interview with CNA #6 on 12/23/13 at 9:55 a.m., she indicated during resident transfers the brakes on a wheelchair needed to be locked. She further indicated a gait belt was to be used on all the residents which need assistance with their activities of daily living. During an interview with CNA #7 on 12/23/13 at 10:03 a.m., she indicated the brakes on a wheelchair needed to be locked before assisting the resident to or from the wheelchair. She also indicated she			

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	used a gait belt on all residents. During an interview with CNA #5 on 12/23/13 at 12:41 p.m., she indicated she had been assisting Resident #B on 10/30/13 without a gait belt. CNA #5 indicated she should have been using a gait belt while providing care for Resident #B. CNA #5 indicated she assisted the resident while she walked to her wheelchair using her walker. The wheelchair brakes were not locked and the wheelchair slid out from under the resident as the resident sat down. CNA #5 indicated Resident #B slid down the side of the bed but did not touch the floor. 3. Review of the current facility procedure, dated 1/2011, titled "TRANSFER: BED-CHAIR/WHEELCHAIR," provided by the Director of Nursing on 12/23/13 at 10:57 a.m., included, but was not limited to, the following: "PURPOSE: To move safely from bed to chair or wheelchair and back again ... ...ONE PERSON-STAND PIVOT: ... ...2 ....Lock wheels of wheelchair ...			

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	...5 ....Apply gait belt to patient ... " 4. Review of the current facility policy, dated 12/2009, titled "GAIT (TRANSFER BELT) POLICY," provided by the Director of Nursing on 12/23/13 at 10:57 a.m., included, but was not limited to, the following: " PURPOSE: To safely and effectively transfer or ambulate a patient ... ...6 ....Place gait belt around waist ....15. When transferring to a wheelchair, prepare chair by locking both wheel brakes ... " 3.1-45(a)(2)			