

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2012
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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: October 1, 2, 3, 4, and 5, 2012</p> <p>Facility number: 001149 Provider number: 155618 AIM number: 200145500</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Michelle Carter, R.N. Heather Lay, R.N. (10/2, 10/5)</p> <p>Census bed type: SNF--38 SNF/NF--32 Residential--63 Total--133</p> <p>Census payor type: Medicare--18 Medicaid--32 Other--83 Total--133</p> <p>Sample: 15 Residential sample: 7</p> <p>These deficiencies reflect State</p>	F0000	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 in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center'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 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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	findings cited in accordance with 410 IAC 16.2.  Quality review completed 10/14/12 Cathy Emswiller RN				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F0225	F 225 SS=D Investigate/Report	11/04/2012			

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	<p>interview, the facility failed to report an allegation of alleged abuse immediately to the facility Administrator, Director of Nursing, or Nurse Supervisor and during an abuse investigation. The deficient practice impacted 1 of 2 residents reviewed for alleged abuse violations from a sample of 2 residents reviewed. [Resident #1]</p> <p>Findings include:</p> <p>1. During entrance conference on 10-1-12 at 10:30 A.M., 2-3 written reports of alleged abuse violations were requested from the Administrator for completion of the "Abuse Prohibition Protocol."</p> <p>On 10-2-12 at 11:15 A.M., the Administrator provided the facility's abuse investigations for Resident #1. At that time, a "Facility Incident Reporting Form" was reviewed.</p> <p>The "Facility Incident Reporting Form" included, but was not limited to, "Incident Date: 6-12-12 approx. 3:00 P.M.... Residents Involved: [Resident #1]... Brief Description of Incident: Staff member reported on 6/13/12 @ 2 PM that a CNA (Certified Nurse Aide) had cursed during care in response to the Resident cursing at</p>		<p><b>Allegations/Individuals</b> It is the practice of this center to comply with F 225 Investigate/Report Allegations/Individuals <b><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></b> Resident # 1's medical record was reviewed and no negative outcome was noted. <b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b> All residents have the potential to be affected by this deficient practice. CNA # 7 &amp; RN # 8 were re-educated on timely reporting of allegations of abuse, neglect and/or misappropriation of property to the facility administrator on (6/13/2012). CNA # 4 is no longer employed at the Center. <b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b> Facility Staff have been re-educated regarding the facility abuse guidelines inclusive of timely notification of abuse, neglect and/or misappropriation of property to the facility administrator. All new employees will be in-serviced upon hire during their orientation regarding the proper procedures and protocols of allegations of abuse.</p>		

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	<p>her..." The "Facility Incident Reporting Form" was submitted to Indiana State Department of Health on 06-15-12.</p> <p>The investigation included a statement from Resident #1 which indicated on 6-13-12 at 15:40 (3:40 P.M.) she was interviewed. She indicated the name of the CNA #7 and stated that she had told the CNA (certified nursing aide) "___ if you don't want to do then don't do it. Then CNA #7 said something___. The resident indicated CNA #4 was in the room. and she had gotten me back into bed.</p> <p>The investigation statement by RN #8 indicated in an interview via telephone on 6-13-12 at 4:10 P.M. that CNA #7 had walked up to RN #8 on 6-12-12 at approximately 3:30 P.M. that Resident #1 had called her a___. RN #8 walked into Resident #1's room and asked her what happened. The resident reported CNA #7 had attitude, and acted as if she doesn't want to be there. The RN told the resident she would have CNA #4 take care of her the rest of the shift.</p> <p>The investigation statement by CNA #4 dated 6/13/12 2:30-3:00 P.M. indicated that she saw Resident #1</p>		<p><b><u>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 in place?</u></b></p> <p>Each Department head or designee will audit a minimum of 5 staff members 3 times per week x 4 weeks on all 3 shifts to validate knowledge retention related to reporting of abuse. The results of the audit will be submitted to the QA&amp;A Committee for further review and recommendations. <b><u>By what date the systemic changes will be completed?</u></b> November 4 th , 2012</p>		

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	<p>being pushed in room by CNA #7. She indicated the resident told CNA #7 You have an attitude go out and come back in and lets start over, CNA #7 replied that she didn't have attitude, Resident #1 indicated she doesn't have to take this____. CNA #7 stated I am not giving you ____.</p> <p>Resident #1 stated 'You little ____ get out get out I don't want you to touch me.' CNA #7 responded stating" if you don't want me to call you a ____ then don't call me a ____" CNA #4 told CNA #7 to leave and she would take care of Resident #1.</p> <p>In an interview with the Administrator on 10/4/12 at 1:45 P.M. that RN #8 had not reported anything to administration regarding discussion with CNA #7 on 6-12-12. He indicated that CNA #4 had brought it to his attention the next day because she felt uncomfortable with what she saw.</p> <p>3.1-28(c)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed related to reporting alleged physical abuse to the Administrator, Director of Nursing, or Supervisor, and State agencies; and did not suspend the alleged violator from work during the facility investigation. The deficient practice impacted 1 of 2 residents reviewed for alleged abuse violations from a sample of 2 residents reviewed. [Resident #1]</p> <p>Findings include:</p> <p>1. During entrance conference on 10-1-12 at 10:30 A.M., 2-3 written reports of alleged abuse violations were requested from the Administrator for completion of the "Abuse Prohibition Protocol."</p> <p>On 10-2-12 at 11:15 A.M., the Administrator provided the facility's abuse investigations for Resident #1. At that time, a "Facility Incident Reporting Form" was reviewed.</p>	F0226	<p><b>F 226 SS=D Development/Implement Abuse/Neglect, ETC Policies</b></p> <p>It is the practice of this center to comply with F 226 Development/Implement Abuse/Neglect, ETC Policies</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- Resident # 1's medical record was reviewed and no negative outcome was noted.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- All residents have the potential to be affected by this deficient practice. CNA # 7 &amp; RN # 8 were re-educated on timely reporting of allegations of abuse, neglect and/or misappropriation of property to the facility administrator on (6/13/2012). CNA # 4 is no longer employed at the Center.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- Facility Staff have been re-educated regarding the facility abuse guidelines inclusive of timely notification of abuse, neglect and/or misappropriation of</p>	11/04/2012

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	<p>The "Facility Incident Reporting Form" included, but was not limited to, "Incident Date: 6-12-12 approx. 3:00 P.M.... Residents Involved: [Resident #1]... Brief Description of Incident: Staff member reported on 6/13/12 @ 2 PM that a CNA (Certified Nurse Aide) had cursed during care in response to the Resident cursing at her..." The "Facility Incident Reporting Form" was submitted to Indiana State Department of Health on 06-15-12.</p> <p>The investigation included a statement from Resident #1 which indicated on 6-13-12 at 15:40 (3:40 P.M.) she was interviewed. She indicated the name of the CNA #5 and stated that she had told the CNA (certified nursing aide) "___ if you don't want to do then don't do it. Then the CNA said something___". CNA #4 got me back into bed. She indicated CNA #4 was in the room.</p> <p>The investigation statement by RN #8 indicated in an interview via telephone on 6-13-12 at 4:10 P.M. that CNA #7 had walked up to RN #8 on 6-12-12 at approximately 3:30 P.M. and stated that Resident #1 had called her a___. RN #8 walked into Resident #1's room and asked her what happened.</p>		<p>property to the facility administrator.</p> <p>All new employees will be in-serviced upon hire during their orientation regarding the proper procedures and protocols of allegations of abuse.</p> <p><u>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 in place?</u></p> <p>- Each Department head or designee will audit a minimum of 5 staff members 3 times per week x 4 weeks on all 3 shifts to validate knowledge retention related to reporting of abuse.</p> <p>The results of the audit will be submitted to the QA&amp;A Committee for further review and recommendations. The results of the audit will be submitted to the QA&amp;A Committee for further review and recommendations.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>- November 4 th , 2012</p>	

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	<p>The resident reported CNA #7 had attitude, and acted as if she doesn't want to be there. The RN told the resident she would have CNA #4 take care of her the rest of the shift.</p> <p>The investigation statement by CNA #4 dated 6/13/12 2:30-3:00 P.M. indicated that she saw Resident #1 being pushed into her room by CNA #7. She indicated the resident told CNA #7, You have an attitude go out and come back in and lets start over. CNA #7 replied that she didn't have attitude, Resident #1 indicated she doesn't have to take this____. CNA #7 stated I am not giving you ____.</p> <p>Resident #1 stated 'You little ____ get out get out I don't want you to touch me.' CNA #7 responded stating" if you don't want me to call you a ____ then don't call me a ____" CNA #4 told CNA #7 to leave and she would take care of Resident #1.</p> <p>In an interview with the Administrator on 10/4/12 at 1:45 P.M. that RN #8 had not reported anything to administration regarding discussion with CNA #7 on 6-12-12. He indicated that CNA #4 had brought it to his attention the next day because she felt uncomfortable with what she saw.</p> <p>10-2-12 at 11:30 A.M., the facility</p>						

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	<p>policy for "Abuse, Neglect and Misappropriate of Patient Property Prevention" dated 4-21-06 was provided.</p> <p>The policy " Abuse, Neglect and Misappropriate of Patient Property Prevention" dated 4-21-06, included the definition of verbal abuse as, "...the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to patients..." The policy also indicated, " The center must follow the time frames established in the regulations ,that is, the center must assure that all alleged violations are reported immediately to the administrator ..."</p> <p>3.1-28(a)</p>			

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F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to provide a sugar-free thickened liquid of resident's choice for a diabetic resident on honey-thickened liquids that preferred sugar-free fluids. This deficient practice impacted 1 of 3 residents reviewed for choices in a sample of 15. (Resident #9)</p> <p>Findings include:</p> <p>The clinical record for Resident #9 was reviewed on 10/4/12 at 11:15 A.M.</p> <p>Diagnoses for Resident #9 included, but were not limited to, end-stage renal disease, high blood pressure, cerebrovascular disease, diabetes mellitus- type 2, polyneuropathy, diabetic retinopathy, uncomplicated vascular dementia, hyperlipidemia, muscle weakness, coronary artery disease, and dysphasia.</p>	F0242	<p><b>F 242 SS=D Self-Determination- Right to Make Choices</b> It is the practice of this center to comply with F 242 SS=D Self-Determination- Right to Make Choices <u><b>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></u> Resident # 9 has been re-approached and informed that a Sugar Free thickened liquid is now available at her request. <u><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></u> Current Alert &amp; Oriented Residents with a thickened liquid restriction and diabetic will be reviewed and informed that a sugar free thickened liquid is available at their request. <u><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></u> Facility Staff have been re-educated</p>	11/04/2012	

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	<p>During the initial tour of the facility on 10/1/12 at 11:20 A.M., with RN #5, she indicated Resident #9 was interviewable and on dialysis.</p> <p>Speech therapy orders on 6/29/12 indicated Resident # 9 was to have honey thickened liquids due to a dysphasia diagnosis.</p> <p>The Kardex (CNA task sheet) on 8/3/12 indicated "honey-like thickened liquids".</p> <p>Nursing notes on 7/2/12 indicated Resident #9 did not like honey thickened liquids. "H2O (water) intake decreased over the last two shifts. Fluids encouraged, but resident drinking very little."</p> <p>Nursing notes dated 7/03/12 to 8/28/12 indicated Resident #9 continued to dislike honey thickened liquids and was not drinking enough fluids.</p> <p>Nursing notes indicated the following:</p> <p>7/03/12 ...HTL (honey thickened liquids) rejected.</p> <p>7/05/12 ...Res (resident) still not drinking enough fluids.</p> <p>7/05/12 Social Services discussed reason for the need of HTL with</p>		<p>regarding Residents' Right to make choices. Dietary and Speech Therapy staff have been educated on "Thickened liquid preparation for liquids not available Pre-Thickened". The offering of a Sugar free drink will be posted with the "Always Available Menu Choices" posted under the Daily Menus and will be discussed at Resident Counsel.</p> <p><b><u>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 in place?</u></b></p> <p>Registered Dietitian or Designee will audit 10 residents weekly x 4 weeks to ensure alternative drink choices are being offered. The results of the audit will be submitted to the QA&amp;A Committee for further review and recommendations. <b><u>By what date the systemic changes will be completed?</u></b> November 4 th , 2012</p>				

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	<p>resident. 7/05/12 ...(Resident #9) very upset regarding having to drink thickened liquids...encouraged to attempt to drink to maintain hydration. 7/06/12 Social Services discussed HTL. 8/21/12 ...continues to complain about thickened liquids &amp; does not seem to hydrate well due to this... 8/28/12 ...requested thin liquids &amp; became very upset when she was told we could not give her thin liquids.</p> <p>A physician progress note dated 9/20/12 indicated "tearful, crying, complaining of thickened liquids."</p> <p>Physician orders dated 9/01/12 indicated "May have ice chips, 1/3 cup with breakfast and dinner."</p> <p>During an interview with Resident #9 on 10/04/12 at 1:50 P.M., Resident #9 said she didn't get enough to drink. She stated, "I don't care for the thickened liquids, it is distasteful!" She continued, "I try to drink and then, hold it in my mouth, like I want to spit it out, because it tastes so bad." She indicated she preferred to drink water, and felt water was best to stay hydrated, but did not like the thickened water. She continued, "I get ice chips, sometimes, if I ask."</p>				

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	<p>Resident #9 stated her drink choices were limited because she had diabetes. She preferred sugar-free choices but indicated she was not offered a sugar-free choice, and was not offered much of a variety of drink choices.</p> <p>On 10/05/12 at 9:20 A.M. the Food Services Director (FSD) said, during an interview, "All thickened liquids, nectar thickened and honey thickened, were pre-packaged items, ordered from a supplier." Available choices for residents were 2% milk, orange juice, cranberry juice, apple juice, and lemon-flavored water. The FSD stated there were not any sugar-free choices for the residents and the food supply order sheet did not have sugar-free choices in the selection.</p> <p>During an interview, on 10/05/12 at 10:30 A.M., with the Registered Dietician (RD), she indicated Resident #9 had been assessed for preferences, but, choices were limited due to the diagnoses of renal disease and diabetes. The RD confirmed Resident #9 was not on any fluid restrictions. Residents with diabetes receive the same thickened liquid choices as non-diabetic residents. The thickened liquid choices were,</p>				

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	<p>milk, orange juice, apple juice, cranberry juice, water, hot chocolate, and coffee. When asked why there were not sugar-free thickened liquid options, the RD said she did not know why.</p> <p>A Food Preference list for Resident #9, dated 9/13/12, indicated the following; Diet: "...honey-thick liquids" and Beverage Selection Preference: Breakfast- "apple (juice), milk", Lunch- "any Pepsi", Dinner- "milk".</p> <p>An itemized meal menu dated 10/05/12, indicated the following beverages were served to Resident #9: Breakfast: HT (honey thickened) milk, HT water, HT apple juice Lunch: HT milk, HT water Dinner: HT milk, HT water</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>			

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F0278 SS=A	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview the facility failed to ensure accuracy in the MDS (Minimum Data Set) assessment regarding the diagnoses for 1 of 15 residents reviewed for MDS in a sample of 15. [Resident #58]</p>	F0278	<p><b>F 278 SS=A Assessment Accuracy/Coordination</b></p> <p>It is the practice of this center to comply with F 278 Assessment Accuracy/Coordination</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p>	11/04/2012	

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	<p><b>Findings include:</b></p> <p>The record review for Resident #58 was completed on 10/3/12 at 11 A.M. Diagnoses included, but were not limited to, traumatic brain injury, depression, quadriplegic, respiratory failure, and high blood pressure. The resident was admitted on 12/26/11.</p> <p>The Admission MDS for January 2012, on the active diagnoses section page 18 of 38, the boxes that are to be marked with an 'x' to indicate current diagnoses for quadriplegia and depression were left blank.</p> <p>The Quarterly MDS for March 2012, on the active diagnoses section page 14 of 33, the boxes that are to be marked with an 'x' to indicate current diagnoses for quadriplegia was left blank.</p> <p>In an interview with the Director of Nursing on 10/5/12 at 9:30 A.M. that the MDS Coordinator indicated to her the MDS for January and March were incorrect.</p> <p>3.1-31(c)(1)</p>		<p>- Resident # 58 has a correction request completed (10/5/2012 on Admission and quarterly MDS) for proper diagnoses.</p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- MDS review was completed for the last 30 days to ensure MDS accuracy. Those identified as inaccurate were corrected per RAI guidelines</p> <p>- <b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- IDT (Inter Disciplinary Team) was in-serviced related to MDS accuracy. The MDS Coordinator and MDS Assistant/Designee will review each other's MDS for Accuracy prior to submission.</p> <p><b><u>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 in place?</u></b></p> <p>The Director of Nursing will complete weekly audits of 3 MDS's x 4 weeks.</p> <p>The results of the audit will be submitted to the QA&amp;A Committee for further review and recommendations.</p> <p><b><u>By what date the systemic changes will be completed?</u></b></p> <p>- November 4 th , 2012</p>		

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F0279 SS=E	<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 interview and record review, the facility failed to ensure that a coordinated Care Plan was developed in conjunction between the facility and a Hospice agency, which clearly outlined the specific responsibilities and services to be provided by each; for 3 of 3 residents reviewed who were receiving Hospice services, in a sample of 15 residents. [Residents #18, #33, and #46]</p> <p>Findings include:</p> <p>1. The clinical record for Resident</p>	F0279	<p><b>F 279 SS=E Development of Comprehensive Care Plans</b></p> <p>It is the practice of this center to comply with F 279- Development of Comprehensive Care Plans</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- Resident # 18, 33, &amp; 46, currently have revised and updated Hospice care plans clearly outlining specific services to be provided by the center and hospice agency.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified</u></p>	11/04/2012			

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	<p><b>#46</b> was reviewed on 10/5/12 at 10:10 A.M. Diagnoses included, but were not limited to, senile dementia-Alzheimer's type, depressive disorder, coronary artery disease with atrial fibrillation, and peripheral vascular disease with history of acute venous thrombosis and embolism.</p> <p>On 5/2/12, the physician wrote an order for "Hospice evaluation and treatment."</p> <p>The most recent M.D.S. [Minimum Data Set] assessment was a quarterly review completed on 8/20/12. The assessment indicated the resident had minimal difficulty hearing and had clear speech, was assessed by staff to be severely impaired for daily cognitive decision-making, required the physical assistance of 1-2 staff for all daily care, and was receiving Hospice services.</p> <p>The facility Care Plan was dated as completed on 9/5/12.</p> <p>One entry addressed a problem area of "Hospice/Palliative care need due to end-state dementia. Pt. [patient] being followed by [name of Hospice agency] since 5/3/12." The "Interventions" were listed as: "Administer medication per physician</p>		<p><b><u>and what corrective action(s) will be taken?</u></b></p> <p>- A chart review of residents with care plans for Hospice has been reviewed and updated on all necessary residents.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- The IDT (Inter disciplinary Team) has been in serviced on development, reviewing and revising the comprehensive plan of care in conjunction with hospice services.</p> <p>Hospice agency will be present at care plan meeting and a review of the care plan in conduction with the IDT team will occur.</p> <p>Hospice care plan are to be placed in residents medical chart for easy accessibility.</p> <p><b><u>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 in place?</u></b></p> <p>- Audit tool will be completed by the Director of Nursing or designee all hospice residents weekly x 4 weeks to ensure that hospice care plans are completed, accurate and in the residents medical chart.</p> <p>The results of the audit will be submitted to the QA&amp;A Committee for further review and recommendations.</p>				

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	<p>order (N); Encourage to participate in activities as able (IDT, HOSPC); Honor advanced directives (ALL); Hospice staff to visit to provide care, assistance, and/or evaluation (HOSPC)." The "N" referred to the facility Nursing staff; the "IDT" referred to the facility Interdisciplinary Team, the "ALL" referred to all facility staff; and the "HOSPC" referred to the Hospice disciplines.</p> <p>A Care Plan, formulated by the Hospice agency, was not found.</p> <p>In the daily conference on 10/5/12 at 12:30 P.M., the Director of Nursing was given the opportunity to submit any documentation/evidence of a coordinated Care Plan that had been formulated between the facility and the Hospice agency.</p> <p>On 10/5/12 at 2:00 P.M., the Director of Nursing provided a print-out of the electronic health record Care Plan maintained by the facility. There were no dates to indicate when the "Focus" ["Problem"] areas and "Interventions" had been initially identified or implemented.</p> <p>One additional facility Care Plan entry addressed a problem of "Spiritual Care (Hospice)." The "Intervention"</p>			

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	<p>was listed as "Provide Spiritual and Pastoral Care, as able (HOSPC)."</p> <p>A Care Plan formulated by the Hospice agency was not provided for review.</p> <p>2. The clinical record for Resident #18 was reviewed on 10/5/12 at 9:20 A.M. Diagnoses included, but were not limited to, muscle weakness/difficulty walking--Rehab, dysphagia with aspiration pneumonitis, altered mental state, chronic obstructive pulmonary disease, osteoarthritis, osteoporosis, and urinary retention.</p> <p>On 9/16/12, the physician gave an order for "Admit [to Hospice]--Failure to thrive."</p> <p>An admission M.D.S. [Minimum Data Set] assessment was completed on 8/30/12. The assessment indicated the resident had adequate hearing with clear speech, was able to understand, had a BIMS [Brief Interview for Mental Status] score of "12" [8-12= moderately impaired cognition for daily decision-making]; required the physical assistance of 1-2 staff for all daily care; and experienced pain.</p>			

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	<p>The most recent facility Care Plan was completed on 9/6/12.</p> <p>An updated Care Plan demonstrating coordination of services with the Hospice agency was not found.</p> <p>A form titled "Initial Orders and Plan of Care," dated 9/16/12, was marked as "Hospice Services." The form included, but was not limited to, the following:</p> <p>"Nurse [Hospice]: 1 visit the first week with 2 PRN [as needed] visits; 1 visit each subsequent week with 3 PRN visits. Nursing assessment of patient/caregiver needs; development of patient/caregiver plan/interventions in collaboration with IDT; evaluation of patient/caregiver response to effectiveness of interventions. Hospice Aide: 1 visit the first week with 2 visits/week on subsequent weeks. Personal care, socialization. Social Worker: 1 visit every month and 3 PRN visits/month. Anticipatory grief needs. Spiritual Care Coordinator: 1 visit/month and 3 PRN visits/month. Intervention of spiritual needs."</p> <p>A form titled "Interdisciplinary Team Plan of Care- PROBLEM #22; Anticipatory Grief and Reaction to</p>			

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	<p>Losses" was dated 9/17/12 and indicated "Hospice Services." The "Interventions" listed were: "Offer/provide emotional support; Offer/provide nonjudgmental atmosphere to facilitate expression of emotions," and were to be provided by the Hospice Social Worker.</p> <p>A form titled "Interdisciplinary Team Plan of Care-PROBLEM #26; Spiritual Needs" was dated 9/19/12 and indicated "Hospice Services." The "Interventions" listed were: "Provide emotional support; Provide spiritual care support for listening, support and praying," and were to be provided by the Spiritual Care Coordinator.</p> <p>3. The clinical record review for Resident #33 was completed on 10/4/12 at 1 P.M. Diagnoses included, but were not limited to, dementia, recurrent urinary tract infections and congestive heart failure.</p> <p>The physician's orders indicated the resident was ordered an evaluation for hospice 6/28/12.</p> <p>The progress notes indicated the Hospice nurse saw the patient</p>			

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	<p>8/22/12 for the first time.</p> <p>At the daily conference on 10/4/12 at 4:15 P.M., a request was made for the current hospice care plan.</p> <p>The DCD (Director of Care Division) on 10/5/12 at 10 A.M. provided undated facility hospice care plan. The care plan indicated, "...Spiritual Care (Hospice)...Provide spiritual and pastoral care [HOSP] (hospice)...FOCUS: Hospice/Palliative care need due to dementia.....INTERVENTIONS: Administer medication per physician orders, Allow patient/family to discuss feelings, etc. Assist to reposition, Assist with DL care and pain management as needed Encourage to participate in activities as able, Honor all advanced directives, Hospice staff to visit to provide care, assistance, and/or evaluation.</p> <p>4. On 10/2/12, the Administrator provided documents titled "General In Patient and Respite Care Skilled Nursing Facility Agreement" as the contract between the facility and the Hospice agency providing care for Residents #18, #33, and #65. The contract was dated 9/26/10, and had an automatic renewal each year.</p>				

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	<p>The contract included, but was not limited to, the following provisions:</p> <p>"... DUTIES AND OBLIGATIONS OF FACILITY ... Plan of Care: Hospice will collaborate with Facility on a coordinated Plan of Care developed jointly between Hospice and Facility. Facility will provide In Patient Services in accordance with Facility's protocols, policies and procedures to the extent they are consistent with Hospice protocols, policies and procedures, and Hospice's Plan of Care for each Hospice Patient....</p> <p>... DUTIES AND OBLIGATIONS OF HOSPICE ... Plan of Care: Hospice will establish a written Plan of Care for each person admitted to Hospice. The plan will be established by the Attending Physician, the Hospice Medical Director of his or her physician designee, and the Hospice Interdisciplinary Team and will be reviewed and updated by these same individuals at intervals specified in the plan.... The plan will state in detail the scope and frequency of services needed to meet the Hospice Patient's and caregiver's needs. Hospice will attend Facility's care conferences and Patient/caregiver meetings as</p>			

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	<p>deemed necessary. Hospice will give Facility a copy of Patient's plan of care....</p> <p>Coordination of Services: ... The Hospice Interdisciplinary Team and Attending Physician will be responsible for developing, reviewing, revising and evaluating each Plan of Care and assuring continuity between all involved agencies and disciplines...."</p> <p>In an interview on 10/5/12 at 11:10 A.M., the Director of Nursing indicated Hospice Care Plans, which were located in the resident's chart, would be the only Care Plan from the Hospice agency. The Hospice agency did not record any information in the facility's computer electronic health records. She indicated the Hospice nurse was always available by telephone, and staff would discuss any issues with the Hospice nurse or aide when they were in the building.</p> <p>3.1-35(c)(2)(C)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155618		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2012	
NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to follow procedure of assessing lung sounds and heart rate before and after a nebulizer treatment for 1 of 1 residents that received nebulizer treatments in a sample of 11 observed during medication pass. [ Resident #8]</p> <p>Findings include:</p> <p>The medication pass was completed on 10-2-12 at 11:26 A.M. with LPN #1. LPN #1 was giving medications to Resident #8. Resident #8 received Albuterol 2.5 mg solution per nebulizer treatment three times a day.</p> <p>On 10-2-12 at 11: 45 A.M. LPN #1 went into the room and paced the correct amount of Albuterol solution into the nebulizer aerosol chamber and then turned on the machine. She</p>	F0328	<p><b>F 328 SS=D Treatment/Care for Special Needs</b></p> <p>It is the practice of this center to comply with F 328 Treatment/Care for Special Needs</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- Resident # 8's clinical record was reviewed. The medication administration record was updated to include pre and post assessment of heart rate and lung sounds.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- A chart Audit was completed on other residents who currently receive nebulizer treatments as part of the plan of care. The medication administration record of residents that receive nebulizer treatments was updated to include pre and post assessment of heart rate and lung sounds.</p> <p><u>What measures will be put into place</u></p>	11/04/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2012
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	<p>had the resident place the aerosol mouthpiece to her mouth and breathe in and out. She did this for ten minutes. The nurse then took the mouthpiece and placed it back into the plastic bag behind the head of the residents bed. LPN #1 then went and documented she had passed the medication.</p> <p>On 10-2-12 at 11:52 A.M. , LPN #1 indicated she listens to the lung sounds about 5 minutes after as well as checking the heart rate.</p> <p>In an interview with LPN # 3 on 10-2-12 at 12 P.M. she indicated the policy states the nurse should listen to lung sounds and check heart rate before and after the nebulizer treatment.</p> <p>The nebulizer policy was provided by the Director of Nursing on 10/4/12 at 3:50 P.M. The policy dated 1-11, indicated, "...7. Assess lung fields and heart rate as applicable...17. Assess lung fields and heart rate and document any changes..."</p> <p>3.1-47(a)(6)</p>		<p><u>or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- Licensed Nursing Staff will be re-educated on guidelines for administration of nebulizer inclusive of completion of the pre and post assessment of heart rate and lung sounds.</p> <p><u>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 in place?</u></p> <p>- Director of Nursing or designee will complete/observe a Nebulizer Treatment of 3 staff a week x 4 weeks to ensure pre and post assessment of heart rate and lung sounds are complete</p> <p>The results of the audit will be submitted to the QA&amp;A Committee for further review and recommendations.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>- November 4 th , 2012</p>		

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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
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F0329 SS=E	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to quantitatively track episodes of behaviors to support the use of psychotropic medications, for 3 of 3 residents reviewed who were receiving an anti-psychotic medication, of 7 residents who received a psychotropic medication in a sample of 15 residents reviewed. [Residents #33, #46, and #65]</p> <p>Findings include:</p>	F0329	<p><b>F 329 SS=E Drug Regimen is Free from Unnecessary Drug</b></p> <p>It is the practice of this center to comply with F 329 SS=E Drug Regimen is Free from Unnecessary Drug</p> <p><u><b>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></u></p> <p>- Resident # 33 &amp; # 46's medical records have been reviewed and updated as needed in order to address their mental, psychosocial, and behavioral symptoms &amp; needs.</p> <p>Resident # 33 was seen by her primary</p>	11/04/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155618		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/05/2012	
NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
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	<p>1. In an interview during the initial orientation tour on 10/1/12 at 11:05 A.M., L.P.N. #2 indicated Resident #65 had behaviors of refusing care "sometimes," being verbally inappropriate, and trying to get up without assistance. The resident had a gastrostomy tube [GT] for nutrition, but was also able to eat regular food.</p> <p>The clinical record for Resident #65 was reviewed on 10/3/12 at 1:00 P.M. Diagnoses included, but were not limited to, severe/advanced dementia--Alzheimer's type, insulin-dependent diabetes with retinopathy and peripheral neuropathy, chronic kidney disease, and ischemic ulcer of the left foot.</p> <p>Physician admission orders on 7/24/12 included, but were not limited to, Quetiapine [Seroquel--an atypical anti-psychotic medication] 25 mg. [milligrams] one tablet by GT every morning, and 50 mg. twice a day at 3:00 P.M. and bedtime.</p> <p>On 8/10/12, the Nurse Practitioner wrote an order indicating the resident had a diagnosis of "Dementia with atypical psychosis."</p> <p>On 8/10/12, a report from a</p>		<p>care physician with documentation that a medication change was not recommended and is contraindicated for this resident related to her diagnosis.</p> <p>Resident # 46 was seen by her primary care physician with documentation that a medication change was not recommended and is contraindicated for this resident related to her diagnosis.</p> <p>Resident # 65 no longer resides at the facility.</p> <p><b><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></b></p> <p>- All residents receiving psychotropic medications have the potential to be affected by the deficient practice and have been identified through chart reviews.</p> <p><b><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>- Social Service Director &amp; Director of nursing has been re-educated on the Mood and behavior Practice guide inclusive of proper procedure identifying, tracking, and analyzing behaviors symptoms on the Mood/Behavior Symptom Log to quantitatively new or existing behaviors of residents in order to address their mental and psychosocial needs.</p> <p>Licensed nursing staff has been Re-educated on the Mood and Behavior Practice guide inclusive of reporting behavior symptoms on the 24HR report that present a safety risk, interfere with care delivery, or are socially inappropriate or stressful to others.</p>				

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	<p>consultant psychologist indicated "Does well during day. At night-behavior escalates, urinates and defecated on floor, pulls out PICC [an intravenous line for administering antibiotic medication], pulls on GT, gets out of bed. Moderate depression=Frustrated by unclear thinking, poor recall, intrusive memories. No signs/symptoms of harm or risk to self or others."</p> <p>On 9/24/12, a report from the consultant psychologist indicated "Distorted reality... Reduced incidence of inappropriate behavior...."</p> <p>An initial/admission M.D.S. [Minimum Data Set] assessment, completed on 8/6/12, indicated the resident had moderate difficulty hearing but had clear speech; usually understood others; had no psychosis [hallucinations or delusions], but had other behavioral symptoms not directed toward others [e.g. hitting or scratching self, pacing, disrobing in public, throwing or smearing food or bodily wastes, verbal/vocal symptoms like screaming, disruptive sounds] that occurred 4 to 6 days in a week but less than daily. The assessment indicated the resident scored a "04" on the BIMS [Brief Interview for</p>		<p><b><u>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 in place?</u></b></p> <p>Social Service Director or designee will complete a Behaviors Process Tool for all mood and behavior systems noted on the 24HR report that present a safety risk, interfere with care delivery, or are socially inappropriate or stressful to others 5 days a week in line with Mood and Behavior Practice Guide and facility policy.</p> <p>The results of the audit will be submitted to the QA&amp;A Committee for further review and recommendations.</p> <p><b><u>By what date the systemic changes will be completed?</u></b></p> <p>November 4 th , 2012</p>		

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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
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	<p>Mental Status] evaluation [0-7=severe impairment in cognitive daily decision-making skills]; required the physical assistance of 1-2 staff for all daily care; had pain issues; and received insulin, anti-psychotic, anti-depressant, and anti-biotic medications.</p> <p>A computer electronic health record entry for "Behavior," in the "Assessment" tab and dated 10/1/12, indicated the following:</p> <p>"Nature of Behavioral Disturbance: Provoked or unprovoked; purposeful; occurs during specific activities. Medications: None of the above. Cognitive Status Problems: Dementia; Alzheimer's disease. Documentation: Resident may become combative with care due to dementia. Has been boxer in past and not always in the present."</p> <p>A second "Behavior" entry, dated 10/3/12, indicated the following:</p> <p>"Nature of Behavioral Disturbance: Provoked or unprovoked; offensive or defensive; purposeful; occurs during specific activities; reaction to a particular action. Medications: None of the above. Cognitive Status Problems:</p>						

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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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	<p><b>Dementia</b> Documentation: Resident can be agitated and hostile and may attempt to hit or kick caregivers. Not always able to redirect."</p> <p>The computer electronic health record section for "Mood/Behaviors" for both Nursing and Social Services had no entries related to behaviors.</p> <p>Computer electronic health record entries for "Skilled Nursing" progress notes, from 8/31/12 through 10/3/12, indicated the following:</p> <p>9/12/12--"... Continues to wander halls late at night and during PMs [evenings] will wander into other patient rooms...."</p> <p>9/15/12--"... Goes into other patients room looking for his room...."</p> <p>9/18/12--"Up on own without assist (walking). Reminded to call for assist but is non-compliant. Undressed himself and put himself to bed without eating dinner. Took left foot dressing off."</p> <p>9/19/12--"Increased level of agitation. Refused Rx [medications]. Refused 10:00 P.M. accu-check. Refused GT feeding. Refused skin assessment. Increased wondering [sic]. Removed dressing on left foot."</p> <p>9/20/12--"Refused to allow treatment</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2012
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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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	<p>on left foot--took meds. After dinner went into another patient's room, took clothes off (completely naked from waist up), and refused to get out of his bed. After explanation, was placed in his own room." 9/26/12--"Refused to eat meals, refused GT feeding, refused treatment to wounds, refused accu-checks. Displayed increased agitation and wondering [sic]." 10/3/12--"Non-compliant with dressing applied at [name of hospital]. Removed both overnight prior to shift. Refused wound care."</p> <p>During the daily conference on 10/4/12 at 3:30 P.M., the Director of Nursing was given the opportunity to supply any documentation related to the specific behavior or behaviors displayed by Resident #65, and were being monitored and tracked to support the use of the anti-psychotic medication this resident was receiving.</p> <p>At the final exit on 10/5/12 at 3:50 P.M., no additional specific and quantitative tracking information was provided for review.</p> <p>2. The clinical record for Resident #46 was reviewed on 10/5/12 at 10:10 A.M. The resident was</p>			

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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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	<p>admitted on 3/14/12 with diagnoses that included, but were not limited to, senile dementia--Alzheimer's type, and depressive disorder.</p> <p>On 5/31/12, the physician wrote an order for Risperdal [an anti-psychotic medication] 0.25 mg. [milligrams] one tablet twice a day--"Diagnosis dementia with behaviors."</p> <p>A quarterly M.D.S. [Minimum Data Set] assessment, dated 8/20/12, indicated the resident had minimum difficulty hearing, had clear speech, and only sometimes understood others. A BIMS [Brief Interview for Mental Status] was "not assessed," but a staff assessment indicated the resident was severely impaired for cognitive daily decision-making. The assessment indicated the resident had no psychosis or behaviors, but was receiving anti-psychotic and anti-depressant medications.</p> <p>There was no documentation in the paper clinical record or in the computer electronic health record identifying the behaviors that prompted the prescription of an anti-psychotic medication.</p> <p>During the daily conference on 10/5/12 at 12:30 P.M., the Director of</p>			

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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
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	<p>Nursing was given the opportunity to provide documentation/evidence of the specific behavior or behaviors displayed by Resident #46, and were being monitored and tracked to support the use of the anti-psychotic medication this resident was receiving.</p> <p>At the final exit on 10/5/12 at 3:50 P.M., no additional specific and quantitative tracking information was provided for review.</p> <p>3. The clinical record for Resident #33 was reviewed on 10/4/12 at 1 P.M. Diagnoses included, but were not limited to, dementia, depression, recurrent urinary tract infections and congestive heart failure. The resident was on Tylenol 650 mg three times a day for pain. On 6/15/12, the physician ordered Risperdal (an anti-psychotic medication) 0.5 mg one tablet every morning. On 6/29/12, the physician changed the dose to 0.5 mg. every morning and 0.75 mg every evening for a diagnosis of dementia with agitation.</p> <p>The initial tour was completed on 10/2/12 at 10:15 A.M. with RN #5. She indicated in an interview at this time that Resident #33 had a</p>						

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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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	<p>behavior of yelling out "help me" frequently. She also indicated the resident had been hospitalized in an acute care hospital psychiatric unit, had been doing better until recently, and believed she was starting to cycle again.</p> <p>The MDS (Minimum Data Set) assessment, dated 2/16/12, indicated the resident had no behaviors. The MDS for 8/15/12 indicated the resident was having behaviors daily.</p> <p>The "Skilled Nursing" progress notes indicated the resident had behaviors on the following dates:</p> <p>Calling out 'help me' repeatedly : 2/17/12, 3/17/12, 3/19/12, 3/21/12, 3/29/12, 3/30/12, 4/8/12, 4/9/12, 4/13/12, 4/16/, 12, 4/21/12, 4/22/12, 4/23/12, 4/24/12, 4/25/12, 4/27/12, 4/28/12, 4/29/12, 4/30/12, 5/1/12, 5/15/12, 5/16/12, 5/17/12, 5/31/12, 6/9/12, 6/26/12, 6/27/12, 6/28/12, 7/7/12, 7/20/12, 7/22/12, 9/2/12, and 9/14/12.</p> <p>Made comments that staff are poisoning her food: 4/27/12, 4/29/12, 4/30/12.</p> <p>Striking out at staff: 5/1/12</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2012
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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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	<p>During the daily conference on 10/4/12 at 3:30 P.M., the Director of Nursing was given the opportunity to supply any documentation related to the specific behavior or behaviors displayed by Resident #33, and were being monitored and tracked to support the use of the anti-psychotic medication this resident was receiving.</p> <p>At the final exit on 10/5/12 at 3:50 P.M., no additional specific and quantitative tracking information was provided for review.</p> <p>4. On 10/5/12 at 2:18 P.M., the Director of Nursing provided blank copies of forms used for the facility's Quality Assurance "Eagle Room" process. The first form, dated 01/2012, was labeled "ISSUE: BEHAVIORS," and had columns for "Date, Name/Room number, Issue, New/Escalating Behavior, Notification, Root Cause, Pain Evaluation, Mood/Behavior Symptom Log, SS [Social Service] Evaluation, Care Plan, P/W Updated." There were lines for multiple resident names and information.</p> <p>The second form, dated 01/2012, was labeled "MOOD/BEHAVIOR SYMPTOM LOG" and had blocks for</p>			

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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
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	<p>each day of the month, and lines for multiple residents' names. The "Directions" indicated: "Use this log with the <i>Eagle Room Behavior Process Tool</i>, the <i>24 Hour Report/Change in Condition</i> report and other appropriate source documents. Patients identified on the <i>Eagle Room Behavior Process Tool</i> are also identified here. Mark under the appropriate day the occurrence of a mood or behavior symptom as noted on the <i>24 Hour Report/Change in Condition</i> report. It is not necessary to show a specific number of symptoms displayed on a particular day. The important information is: 1) the pattern when symptoms are displayed, e.g., consecutive vs. intermittent days, and 2) a reduction in the display of the symptoms as staff work to address and resolve them by using care plan approaches, patient preferences and a consistent care routine."</p> <p>In an interview on 10/5/12 at 2:18 P.M., the Director of Nursing and the Social Service Director indicated a behavior displayed by a resident was written on a large "Eagle Room" board, and was reviewed and discussed on a daily basis during the morning meeting. Each indicated they were not aware of any system to</p>						

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	<p>record individual resident behaviors in a resident's clinical paper chart or in the electronic health record, in order to maintain a quantitative tracking system.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F0441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F0441	F 441 SS=D Infection Control	11/04/2012			

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	<p>ensure that appropriate handwashing measures were performed prior to administering prepared medications to 1 of 1 resident; and failed to ensure that 1 of 4 residents, admitted since the last annual survey on 8/19/11, received a second step PPD [Purified Protein Derivative] tuberculin skin test for tuberculosis, in a sample of 15 residents reviewed. [Resident #50 and #162]</p> <p>Findings include:</p> <p>1. In an interview during the initial orientation tour on 10/1/12 at 11:05 A.M., L.P.N. #2 indicated Resident #50 was admitted to the facility after experiencing a fall at home and sustaining a fractured pelvis.</p> <p>The clinical record for Resident #50 was reviewed on 10/2/12 at 10:10 A.M. The resident was admitted on 9/7/12 with diagnoses that included, but were not limited to, pelvic ring fracture, osteoporosis, muscle weakness/difficulty walking, and hypertension.</p> <p>An initial PPD skin test was given upon admission on 9/7/12, and was read on 9/10/12. The test was negative.</p>		<p>It is the practice of this center to comply with F 441 Infection Control</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- Resident # 50 2-Step Mantoux screening was started over on 10/4/2012 (1 st Step Read- &amp; 2 nd Step Read-). Resident # 50's clinical record was reviewed and no negative outcomes were noted.</p> <p>Resident # 162 no longer resides at the facility. LPN # 2 was re-educated on Hand washing 10/3/2012.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- All residents have the potential to be affected by the deficient practice</p> <p>A full audit was completed to ensure a 2-step Mantoux screening was done on each resident</p> <p>- <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- All Staff will be re-educated on guidelines for proper hand washing.</p> <p>Licensed nursing staff will be re-educated on Patient Screening Guidelines inclusive of the 2-step Mantoux Test and time frames between 1 st &amp; 2 nd Steps.</p> <p><u>How the corrective action(s) will be</u></p>				

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	<p>A second step PPD was not found in the paper or electronic health records.</p> <p>During the daily conference on 10/3/12 at 3:15 P.M., the Director of Nursing was given the opportunity to submit either documentation of a second step PPD test completed within 1-3 weeks after the first test or a documented negative tuberculin skin test result during the preceding 12 months.</p> <p>In an interview on 10/4/12 at 10:30 A.M., the Director of Nursing indicated a second step PPD was not done, and she had no information related to a documented negative tuberculin test result in the preceding 12 months. She indicated the process [first and second step PPD] was being started over again.</p> <p>On 10/5/12 at 2:18 P.M., the Director of Nursing provided a paper titled "Patient Screening Guidelines," dated 9/29/09. The paper included, but was not limited to, the following information: "A 2-step Mantoux [PPD] test is administered, per physician order, to patients within 24 hours of admission. Step-1 is given prior to or upon admission and read within 48-72 hours of administration and Step-2 is administered 7-14 days</p>		<p><u>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>Director of Care Delivery or designee will observe hand washing with a minimum of 10 staff per week on all shifts for proper techniques per facility guideline x 4 weeks.</p> <p>- Director of Nursing or designee will monitor/audit all new admissions for 2-step Mantoux test per center policy x 4 weeks to ensure completion</p> <p>The results of the audits will be submitted to the QA&amp;A Committee for further review and recommendations.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>- November 4 th , 2012</p>		

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	<p>after reading the 1st. step and read within 48-72 hours...."</p> <p>2. The medication pass was completed on 10-3-12 at 7:30 A.M. with LPN #2. LPN #2 was giving medications to Resident #162.</p> <p>Resident #162 received a blood glucose check and ten oral medications at 8 AM.</p> <p>LPN #2 took Resident #162's blood sugar and then washed his hands. He then went to the medication cart where he proceeded to punch out all of the medications that Resident #162 required at this time. On his way to Resident #162's room, with the medications and water in his one hand, he helped to push a resident into the lounge area and went to the desk and helped give paperwork that was sitting at the nurses desk to another resident. He then proceeded to Resident #162's room to give the resident his medication. He then assisted the resident to the dining room area. LPN #2 was not observed washing his hands or using hand sanitizer. He stood in the dining area for 5 more minutes and was not observed leaving to wash his hands.</p>			

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R0000	<p>In an interview with the Director of Nursing(DON) on 10/5/12 at 12:50 P.M. after indicating what transpired during the observation with LPN #2 during med pass, she indicated she would have expected the nurse to use hand sanitizer wash their hands.</p> <p>A policy dated 12/09 for handwashing was provided by the DON on 10/5/12 at 2:10 P.M. The policy indicated, "...When to wash hands or use an alcohol-based hand rub: -After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient..."</p> <p>3.1-18(f) 3.1-18(l)</p> <p>The following State Residential findings are cited in accordance with 410 IAC 16.2.</p>	R0000	<p>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 in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p>		

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R0216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to accurately document the self medication evaluation of a resident who self-administers medications. This deficient practice affected 1 of 1 residents reviewed for self-administration of medications in a sample of 7 residents reviewed. [Resident #136]</p> <p>Findings include:</p> <p>On 10/2/12 at 2:45 P.M., Resident #136's record was reviewed. Diagnoses included, but were not limited to, early diabetes mellitus, hypertension and osteoporosis.</p> <p>A semi-annual evaluation, dated 8/1/12, included, but was not limited</p>	R0216	<p><b>R 216- Evaluation</b></p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u></p> <p>- - Resident #136 will be reevaluated for self administration abilities and completed, signed and dated.</p> <p>- - <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</u></p> <p>All other residents who currently self medicate will have their clinical record audited to identify any omission of checked boxes on self administration assessment. Any other omissions will be addressed and/or reassessed.</p> <p>-</p>	11/04/2012			

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	<p>to, "Medication Administration: No assistance with medications required... self medicates... Cognitive Mental Status: No apparent memory loss or psychiatric impairment..."</p> <p>A "Self-Administration of Medication" evaluation, dated 8/1/12, included, but was not limited to, "Step 1: Self-Administration of Medication: [marked by Resident #136]: I wish to self-administer my medications if this practice is determined, by the interdisciplinary team, to be safe... Step II: Assessment of Patient's Ability to Self-Medicate: [included a test completed by the resident listing all daily medications]... Please check appropriate box: Patient demonstrates ability to for safe self-administration of medication and Patient unable to demonstrate ability for safe self-administration [neither box was marked]... Step III: Seven Day Evaluation of Patient Self-Administering Medication: [section not completed]..."</p> <p>The self-administration evaluation was not accurately completed by the facility. Sections II and III were not completed.</p> <p>On 10/2/12 at 3:30 P.M., in an interview, the Residential Wellness</p>		<p>- <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</u></p> <p>-</p> <p>The Wellness Director and an additional nurse will be in-serviced. One on one regarding 410 IAC 16.2-5-2 (e) 1-5 Evaluation and completion procedure of the self administration of medications.</p> <p>-</p> <p>- <u>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;</u></p> <p>-</p> <p>The Wellness Director will be responsible for the ongoing monitoring of all evaluations including self administration assessments.</p> <p>-</p> <p>- <u>By what date the systemic changes will be completed;</u></p> <p>-</p> <p><b>November 4, 2012.</b></p>		

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	<p>Director indicated she was aware the self-medication evaluation was not entirely completed; however, the resident was able to list all her medications and was therefore able to self-medicate.</p> <p>On 10/5/12 at 2:20 P.M., the Residential Wellness Director provided "Self Administration of Medications" policy and procedure dated 7/04.</p> <p>The policy and procedure included, but was not limited to, "Policy: To offer every resident a life full of independence and freedom, resident who have cognitive and physical ability to take their own medication are encouraged to do so... Procedure: The nurse at the community/facility must also evaluate each resident who self-administers his or her medication by completing the "Self-Administration of Medication Assessment" form... The nurse will approve each resident that self-administers medication to ensure safe and effective procedures are followed... Periodic evaluations of the resident's ability to self-administer medications must be made to ensure that safe and effective procedures are followed every day..."</p>				

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R0217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to obtain the resident's signature on the agreed upon service plan for 4 of 7 residents reviewed for completed service plans [Residents #77, 81, 154 and 155], the facility failed to identify services provided to a resident on Coumadin</p>	R0217	<p><b>R 217: Evaluation</b></p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>1. Resident #81 has reviewed his previous service plan and signed the assessment dated 10/2/12.</p>	11/04/2012			

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	<p>[anti-coagulant] for 1 of 1 resident [Resident #77] reviewed on Coumadin in a sample of 7 residents reviewed, and the facility failed to complete a semi-annual evaluation for 1 of 7 residents reviewed for timely evaluations in a sample of 7 residents reviewed. [Resident #136]</p> <p>Findings include:</p> <p>1. On 10/2/12 at 2:10 P.M., Resident #81's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.</p> <p>A "Change of Condition" service plan, dated 11/2/11, did not include a signature from the resident or the resident's responsible party.</p> <p>2. On 10/5/12 at 10:55 A.M., Resident #154's record was reviewed. Diagnoses included, but were not limited to, dementia, bladder cancer, and osteoporosis.</p> <p>An "Initial" service plan, dated 5/16/12, did not include a signature from the resident or the resident's responsible party.</p> <p>3. On 10/5/12 at 11:15 A.M., Resident #155's record was reviewed. Diagnoses included, but were not</p>		<p>1. Resident #154 is deceased and unable to sign her initial service plan dated 5/16/12.</p> <p>1. Resident #155 has been discharged and is unable to review and sign the service plan completed 11/30/11.</p> <p>1. Resident #77 has reviewed and signed the service plans dated 10/7/11, 3/28/12 and 9/12/12. The service plan of 9/12/12 has been updated to include laboratory testing related to the Coumadin therapy and observation for bruising/bleeding.</p> <p>1. When it was discovered that resident #136 did not have a timely semi-annual evaluation, the Wellness Director immediately completed an updated evaluation on 8/1/12. Resident #136 is scheduled for another semi-annual assessment on 2/1/13.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- All current resident clinical records have been audited for timely review and signature of the resident. If the resident is unable to sign, their legal representative was contacted to sign.</p> <p><u>What measures will be put onto place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- All subsequent assessments/evaluations will be reviewed and signed by the resident and/or legal representative.</p> <p><u>How the corrective action(s) will be</u></p>				

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	<p>limited to, dementia and hypertension.</p> <p>A "Semi-Annual" service plan, dated 11/30/11, did not include a signature from the resident or the resident's responsible party.</p> <p>4. On 10/2/12 at 1:25 P.M., Resident #77's record was reviewed. Diagnoses included, but were not limited to, pain and constipation.</p> <p>The following service plans were not signed by the resident or the resident's responsible party: A change of condition, dated 10/7/11, a semi-annual, dated 3/28/12, and a semi-annual, dated 9/12/12.</p> <p>In addition, Resident #77's above service plans did not include services provided by the facility regarding Coumadin therapy.</p> <p>An "Admission Physicians Orders" dated 10/11/11, included, but was not limited to, "Warfarin [Coumadin] 2 milligrams by mouth..."</p> <p>A "Physicians Orders" dated 9/21/12, included, but was not limited to, "Warfarin Sodium 4 milligrams by mouth..."</p>		<p><u>monitored to ensure the deficient practice will not recur is , what quality assurance program will be put in place?</u></p> <p>- The Wellness Director and Executive Director will review for completion of signatures. Residents currently on Coumadin therapy will have related services documented on their service plans. The Wellness Director will monitor the service plans of all residents on Coumadin therapy to ensure that related laboratory testing and precautions are listed.</p> <p><u>By what date the systemic changes will be completed?</u></p> <p>- November 4, 2012.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/05/2012
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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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	<p>On 10/2/12 at 2:00 P.M., in an interview, the Residential Wellness Director indicated she usually puts laboratory testing and how staff check for bruising for all residents taking Coumadin and must have missed it on Resident #77.</p> <p>5. On 10/2/12 at 2:45 P.M., Resident #136's record was reviewed. Diagnoses included, but were not limited to, early diabetes mellitus, hypertension, and osteoporosis.</p> <p>A "Semi-Annual" service plan was dated 10/5/11 and 8/1/12. There was no documentation of a semi-annual evaluation for April, 2012 [the next scheduled semi-annual].</p> <p>On 10/2/12 at 3:30 P.M., in an interview, the Residential Wellness Director indicated the April evaluation was missed for the resident and completed 4 months later on 8/1/12 after a chart audit.</p>			

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R0410	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure annual tuberculin skin testing was completed on a resident. The deficient practice affected 1 of 7 residents reviewed for adequate tuberculin skin testing in a sample of 7 residents reviewed. [Resident #114]</p> <p>Findings include:  On 10/2/12 at 2:25 P.M., Resident #114's record was reviewed. Diagnoses included, but were not</p>	R0410	<p><b>R 410 – Infection Control</b></p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the non-compliance?</u></p> <p>- Resident #114 received his annual tuberculin skin test on 10/2/12 and was read 10/4/12 as 0 mm of induration. Resident #114 is rescheduled for another annual TB skin test on 10/4/13.</p> <p><u>How other residents having the potential to be affected by the same non-compliant practice will be identified and what corrective action(s) will be taken?</u></p> <p>- All current resident clinical records were</p>	11/04/2012

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	<p>limited to, hypertension, chronic obstructive pulmonary disease, depression, and anemia.</p> <p>Resident #114 was admitted to the facility on 7/9/10.</p> <p>A "Patient Immunization Record" included, but was not limited to, "1st step Mantoux: Year 2011: Date Administered: 5/9/11... Year 2012: [no date]..."</p> <p>On 10/2/12 at 2:45 P.M., in an interview, the Residential Wellness Director indicated she must have missed the resident's yearly tuberculin skin test for 2012 and that she would administer the test that day.</p> <p>There was indication in Resident #114's record regarding active tuberculosis.</p> <p>On 10/5/12 at 2:20 P.M., the Residential Wellness Director provided "Tuberculosis Screening" dated 11/04, policy and procedure.</p> <p>The policy and procedure included, but was not limited to, "Policy: It is the policy of this facility to provide a safe, sanitary, and comfortable environment and to help prevent the</p>		<p>reviewed for timely tuberculin skin testing.</p> <p>All current residents have current TB skin testing results and are present in their clinical records.</p> <p><b><u>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></b></p> <p>-</p> <p>Initial 2-step TB tests and subsequent annual TB tests will be logged on and maintained in a monthly tickler file. Each month, the Wellness Director will for completion of timely TB testing.</p> <p><b><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put in place?</u></b></p> <p>-</p> <p>The Wellness Director will provide ongoing monitoring of all initial and subsequent annual TB skin testing utilizing the updated listing and established month tickler file.</p> <p><b><u>By what date the systemic change will be completed?</u></b></p> <p>- November 4, 2012</p>		

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	development and transmission of diseases and infection by establishing an infection control program that includes the tuberculin skin tests prior to or upon admission and annually thereafter... Mantoux skin tests shall be administered according to recommended protocol and results shall be read by a designated licensed nurse on an annual basis..."			