

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00120382.</p> <p>Complaint IN00120382 Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: December 12, 13, 17,18, 19, 2012</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Survey team: Karen Lewis, RN, TC Ginger McNamee, RN Betty Retherford, RN Toni Maley, BSW Lynn Mackey, RN [December 12, 13, 17, 2012]</p> <p>Census bed type: SNF/NF: 22 SNF: 122 Total: 144</p> <p>Census payor type: Medicare: 14 Medicaid: 111 Other: 19</p>	F0000	<p>January 7, 2013</p> <p>Long Term Care Division, 4 th Floor 2 North Meridian Street Indianapolis, IN 46204</p> <p>RE: ManorCare Health Services of Anderson 1345 N. Madison Ave. Anderson, IN 46011</p> <p>Dear Kim Rhoades:</p> <p>Please note our Plan of Correction and allegation of compliance for the Recertification and State Licensure Survey completed on December 19, 2012. We respectfully request a desk review.</p> <p>Should you have any other questions or need additional information, please contact me at the above address or phone number. You may also contact me via email at 421admin@hcr-manorcare.com.</p> <p>Sincerely,</p> <p>Nicole Fields, HFA Administrator</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>Total: 144</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Debora Barth, RN.</p>				

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F0156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure residents were informed of possible charges that could be incurred as a result of the lack of Medicare coverage benefits for 4 of 4 residents reviewed who had received notification of Medicare non-coverage. (Resident #'s 21, 55, 195 and 223)</p> <p>Findings include:</p> <p>Review of the "Notice of Medicare Provider Non-Coverage" letters for Resident #'s 21, 55, 195 and 223 on 12/18/12 at 3:28 p.m., indicated the letters lacked information related to a list of items and services with charges for non-Medicare residents and what the resident's daily rate would be when Medicare services were</p>	F0156	<p>Tag F 156</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Residents #21, 55, 195, and 223 have discharged from the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Resident(s) that are exhausting Medicare benefits or receiving cut letter notice have the potential to be affected by the deficient practice.</p> <p>Medicare notice of non-covered charges will be maintained in</p>	01/18/2013

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>discontinued.</p> <p>During an interview on 12/19/12 at 9:27 a.m., the Administrator indicated she was not aware it was necessary to have this information listed on the non-coverage letters and would implement that procedure on future letters.</p> <p>3.1-4(f)(3)</p>		<p>accordance with the CMS guidelines.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Social Services, Business office, Medical Records and MDS staff were educated on proper completion of the notification and documentation of Medicare non coverage per the CMS guidelines.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>Business Office Manager or designee will monitor compliance with notification and documentation of Medicare non coverage.</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p> <p>By what date the systemic changes will be completed? January 18, 2013</p>		

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 12/19/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
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 record review and interview, the facility failed to ensure a comprehensive health care plan was developed related to leukemia, hypertension requiring medication administration, chronic urinary tract infections, and risk for self-harm for 4 of 10 residents reviewed for unnecessary medications. (Resident #'s 32, 3, 34, and 84.)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #34 was reviewed on 12/17/12 at</p>	F0279	<p>Tag F279</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #34s comprehensive health care plan was updated to include hypertension.</p> <p>Resident #84s comprehensive health care plan was updated to include hypertension, chronic urinary tract infection and history of self-harm.</p>	01/18/2013	

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>11:04 a.m.</p> <p>Diagnoses for Resident #34 included, but were not limited to, hypertension, depression, osteoporosis, and anxiety.</p> <p>The clinical record indicated Resident #34 received Diltiazem (a blood pressure medication) 180 milligrams (mg) once a day at bedtime. The original order date for the medication was 12/5/11.</p> <p>The clinical record lacked any comprehensive health care plan (HCP) having been developed related to Resident #34's diagnosis of hypertension requiring the need for a blood pressure medication.</p> <p>During an interview with the Director of Nursing (DoN) on 12/19/12 at 11:37 a.m., additional information was requested related to the lack of any comprehensive HCP having been developed related to the resident's use of a blood pressure medication.</p> <p>The facility failed to provide any comprehensive HCP related to the resident's use of a blood pressure medication created before 12/19/12.</p>		<p>Resident #32s comprehensive health care plan was updated to include chronic lymphocytic leukemia</p> <p>Resident #3s comprehensive health care plan was developed to include hypertension.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>Residents with hypertension, diagnosis of leukemia, chronic urinary tract infection and history of self-harm have the potential to be affected by the same deficient practice. Their comprehensive health care plans have been reviewed and updated as appropriate.</p> <p>Comprehensive health care plans will be developed, reviewed and/or revised based on the resident's assessment.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed nursing staff were educated on Care Plan guidelines and preparation of comprehensive health care plans. See Attachment A.</p>		

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>2.) The clinical record for Resident #84 was reviewed on 12/18/12 at 9:14 p.m.</p> <p>Diagnoses for Resident #84 included, but were not limited to, hypertension, depression, delirium secondary to urinary tract infection, and a history of self-harm.</p> <p>Resident #84 had physician's orders for the following:</p> <p>A. Hydrochlorothiazide (a blood pressure medication) 25 milligrams (mg), 1 tablet by mouth once a day. The original date of this order was 11/15/12.</p> <p>B. Metoprolol tartrate (a blood pressure medication) 25 mg, 1/2 tablet by mouth twice a day. The original date of this order was 11/15/12.</p> <p>C. Macrochantin (an antibiotic) 50 mg, 1 tablet by mouth once a day, for the prevention of a urinary tract infection. The original date of this order was 11/17/12.</p> <p>D. Wellbutrin XL (an antidepressant medication) 300 mg, 1 tablet by mouth once a day. The original date of this order was 11/15/12.</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>Monitoring will be completed by the ADNS or designee basis a minimum of 5 days per week regarding completion of comprehensive care plans for new admissions, change in condition, review of comprehensive care plans, and revisions of care plans as needed. See attachment B.</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p> <p>By what date the systemic changes will be completed? January 18, 2013</p>				

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>E. Cymbalta (an antidepressant medication) 60 mg, 2 tablets by mouth once a day. The original date of this order was 11/15/12.</p> <p>The clinical record lacked any comprehensive health care plans (HCP) having been developed related to Resident #84's diagnoses of hypertension, chronic urinary tract infections, and a history of self-harming behaviors requiring the need for medications.</p> <p>During an interview with the Director of Nursing (DoN) on 12/19/12 at 11:37 a.m., additional information was requested related to the lack of any comprehensive HCP having been developed related to the resident's diagnoses of hypertension, chronic urinary tract infections, and a history of self-harming behaviors requiring the need for medications.</p> <p>The facility failed to provide any comprehensive HCP related to the resident's diagnoses of hypertension, chronic urinary tract infections, and a history of self-harm requiring the need for medications created before 12/19/12.</p> <p>3.) The clinical record for Resident #32 was reviewed on 12/17/12 at</p>			

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>12:45 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, hypertension, congestive heart failure, and history of supraventricular tachycardia (an abnormally rapid heart rate).</p> <p>A hospital discharge summary, dated 10/7/12, indicated the resident had multiple health concerns including chronic lymphocytic leukemia (a progressive blood disease characterized by abnormally elevated white blood counts), currently stable.</p> <p>The most recent complete blood count in the resident's clinical record was dated 10/21/12. His white blood count was slightly elevated at 11.77 - normal range 4.0-11.0.</p> <p>The clinical record lacked any comprehensive health care planning related to his diagnosis of chronic lymphocytic leukemia.</p> <p>During an interview on 12/18/12 at 3:50 p.m., the DoN indicated she had been unable to find any comprehensive health care plan related to the resident's diagnosis of chronic lymphocytic leukemia.</p> <p>4.) The clinical record for Resident</p>				

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>#3 was reviewed on 12/17/12 at 8:40 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, hypertension, anemia, and diabetes mellitus.</p> <p>The clinical record indicated the resident's speech was garbled on 7/12/12 at 2:45 p.m. Her blood pressure was 184/140. She was sent to the emergency room at that time and was admitted for treatment for multiple health issues including cellulitis and malignant hypertension. She returned to the facility on 7/19/12.</p> <p>Physician's orders, signed 12/5/12, indicated the resident took the following blood pressure related medications:</p> <p>Amlodipine Besylate (an antihypertensive) 5 milligrams tab 1 daily and Lisinopril (an antihypertensive) 10 mg tab 1 daily.</p> <p>The original date of the two orders was 7/20/12.</p> <p>The last blood pressure documented in the resident's clinical record was taken on 8/22/12 and was 146/76.</p>			

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The clinical record lacked any comprehensive health care plan for the resident's diagnoses of hypertension including how often her blood pressure was to be checked.</p> <p>During an interview with the DoN on 12/18/12 at 1:20 P.M., additional information was requested related to the lack of health care planning for the resident's diagnosis of hypertension requiring medications to control.</p> <p>During an interview on 12/18/12 at 3:00 p.m., the DoN indicated no health care plan had been developed related to the resident's diagnoses of hypertension and one had been developed now.</p> <p>5.) Review of the current policy, dated 8/2009, titled "Minimum Record Content", provided by the DoN on 12/18/12 at 1:00 p.m., included, but was not limited to, the following:</p> <p>"...Care Plans</p> <p>Upon admission, a care plan is developed to address the primary reason for admission and treatment of the patient's most immediate care needs...."</p>			

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	3.1-35(a)			

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure residents who had orders for laboratory services and residents who needed monitoring of medications received laboratory and vital signs monitoring for 2 of 10 residents who were reviewed for nursing monitoring services (Resident #146 and #153).</p> <p>Findings:</p> <p>1.) Resident #146's record was reviewed on 12/19/12 at 8:41 a.m.</p> <p>Resident #146's current diagnoses included, but were not limited to, Alzheimer's disease, hypothyroidism and hypertension.</p> <p>Resident #146 had current 12/12,physician's orders for the following:</p> <p>a.) CBC (Complete Blood Count), CMP (Complete Metabolic Profile), Lipids every 3 months. This order originated 5/22/11.</p>	F0282	<p>Tag F282</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The Physician for resident #146 was contacted and orders for labs were received and carried out per the physician's order.</p> <p>Blood pressure and heart rate will be obtained for resident #153 prior to administering medication.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. Audits included residents receiving Antihypertensive medications and lab services. Necessary corrective action taken as appropriate.</p>	01/18/2013			

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>b.) Sever Iron, Ferritin, B12, Folate Level and TSH (Thyroid Stimulating Hormone) yearly. This order originated 7/1/12.</p> <p>The clinical record lacked any Sever Iron, Ferritin, B12, Folate Level, TSH level or CMP. The most current CBC on the record was 7/10/12.</p> <p>Resident #146 had a current ,12/12, care plan problem/need regarding cardiac disease related to ischemic heart disease with cerebral infarct and venous thrombosis embolism. An approach to this problem was to obtain labs as ordered.</p> <p>Resident #146 had a current, 12/12, care plan problem/need regarding being at risk for an altered nutritional status due to Alzheimer's disease and renal insufficiency. An approach to this problem was to obtain labs as ordered.</p> <p>During a 12/19/12, 2:20 p.m. interview, the Director of Nursing indicated Resident #146's above labs had not been drawn. She indicated she had a current call out to Resident #146's physician to determine how he would like to address the error. She also indicated labs had expired and</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nurses have been provided education on obtaining vital signs and lab monitoring guidelines. See attachment C.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>The Director of Care Delivery or Designee will conduct Medication Administration observations on each shift of licensed nursing staff weekly to include nurses on days, evenings, nights and weekends for a total of 12 observations per week to observe for obtaining and documenting required vital signs.</p> <p>The Director of Care Delivery or Designee will complete monitoring daily, five days a week, of documentation to validate that lab services were obtained per physician orders. See attachment D.</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter for a minimum of six months. QA&A committee will review findings</p>		

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>were not renewed by nursing staff.</p> <p>Review of an 8/11/06, current facility policy titled "Laboratory Tracking Guidelines", which was provided by the Director of Nursing on 12/19/12 at 2:17 p.m., indicated the following;</p> <p>"Purpose: To establish guidelines to track the completion, reporting and monitoring of laboratory tests and results... The lab tracking log is reviewed each night, or per center protocol, and requisitions completed for the next day... Receipt of laboratory results: ...lab is contacted for results not received." 2). Resident #153's clinical record was reviewed on 12/18/12 at 11:03 a.m. The resident's diagnoses included, but were not limited to, stroke, cardiomyopathy, and delusions.</p> <p>The resident's current physician's orders were signed by the physician on 12/19/12. The resident's orders included, but were not limited to, amlodipine besylate [for high blood pressure] 2.5 mg take 1 by mouth once daily, hydralazine [for high blood pressure] 50 mg take 1 tablet by mouth every 6 hours, lisinopril [for</p>		<p>and determine need for further monitoring and/or education per the QA&A process.</p> <p>By what date the systemic changes will be completed? January 18, 2013</p>		

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>high blood pressure] 2.5 mg by mouth once a day, and metoprolol tartrate [for high blood pressure] 50 mg tablet take 1 tablet by mouth twice a day and hold if the systolic blood pressure is less than 100 or the heart rate is less than 60 beats per minute. The order for metoprolol tartrate originated on 4/11/11.</p> <p>The resident had a care plan problem initiated on 2/9/11 and carried forward for cardiac disease related to hypertension. Interventions for this problem included, but were not limited to, administer medication as per MD orders and observe for effectiveness and to observe for and report adverse changes in the pulse rate.</p> <p>Review of the Medication Administration Records and Nurses Progress Notes lacked an indication of heart rate monitoring and/or blood pressure monitoring on the following dates and times when the metoprolol tartrate was given: 11/1/12 at 8:00 p.m. 11/2/12 at 8:00 p.m. 11/3/2 at 8:00 p.m. 11/4/12 at 8:00 p.m. 11/7/12 at 8:00 a.m. 11/9/12 at 8:00 p.m. 11/11/12 at 8:00 a.m. 11/12/12 at 8:00 p.m.</p>						

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>11/13/12 at 8:00 p.m. 11/14/12 at 8:00 p.m. 11/15/12 at 8:00 p.m. 11/13/12 at 8:00 p.m. 11/18/12 at 8:00 p.m. 11/18/12 at 8:00 p.m. 11/19/12 at 8:00 p.m. 11/20/12 at 8:00 p.m. 11/21/12 at 8:00 p.m. 11/24/12 at 8:00 a.m. 11/27/12 at 8:00 p.m. 11/28/12 at 8:00 p.m. 12/3/12 at 8:00 a.m. 12/4/12 at 8:00 a.m. and 8:00 p.m. 12/5/12 at 8:00 a.m. and 8:00 p.m. 12/6/12 at 8:00 a.m. and 8:00 p.m. 12/7/12 at 8:00 a.m.</p> <p>During an interview with the Director of Nursing on 12/19/12 at 2:17 p.m., she indicated she could find no more information related to the monitoring of the medication.</p> <p>3.5-35(g)(2)</p>			

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on clinical record review and interview, the facility failed to ensure assessment and monitoring was completed for 1 of 3 residents (Resident #32) reviewed for monitoring following a noted change in condition requiring an emergency room evaluation and failed to ensure dialysis assessments were made and communication maintained with the dialysis provider for 1 of 1 resident receiving dialysis services. (Resident #66)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #32 was reviewed on 12/17/12 at 12:45 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, hypertension, congestive heart failure, history of supraventricular tachycardia, and diabetes mellitus.</p> <p>A health care plan problem, revised</p>	F0309	<p>Tag F309</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Clinical record review completed for resident #32. Documentation currently reflects the residents overall condition as stable.</p> <p>Clinical record review completed for resident #66 and reflects that necessary dialysis communication tools are in place.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. The audit included residents with change in condition and residents receiving dialysis therapy. Necessary corrective action taken</p>	01/18/2013			

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>on 10/15/12, indicated Resident #32 had cardiac disease related to hypertension and congestive heart failure. One of the approaches for this problem was "Observe for and report adverse changes in respiratory effort, pulse rate, dizziness, shortness of breath, chest pain, edema, vital signs, and general condition."</p> <p>A nursing note entry, dated 9/14/12 at 10:35 p.m., indicated the resident complained of shortness of breath and neck pain. His pulse was elevated at 129 beats per minute. His oxygen saturation rate varied between 88-90 % on room air. The physician was called and the resident was sent to the emergency room for evaluation and treatment.</p> <p>The next nursing note entry, dated 9/15/12 at 2:38 a.m., indicated the resident had returned from the hospital with no new orders. The note indicated the resident had no complaints at that time. No vital signs were documented. The note indicated "will continue to monitor."</p> <p>The clinical record lacked any monitoring of oxygen saturation levels or vital signs from his 9/15/12 emergency room return through 9/19/12. Routine vital signs were</p>		<p>as appropriate.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nurses have been provided education on the Change in Condition Guidelines and Alert Charting Guidelines. See attachment E.</p> <p>Licensed Nurses have been provided education on the Dialysis Communication Guidelines. See attachment E.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>The Director of Care Delivery or Designee will conduct daily monitoring of residents with change in condition which will include but is not limited to residents that have required and Emergency Room evaluation, hospital stay or change in condition requiring physician or Nurse Practitioner intervention. Monitoring will identify and validate that alert charting is completed per guidelines. See attachment F.</p> <p>The Director of Care Delivery or</p>		

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>taken on 9/19/12 at 8:59 p.m. His blood pressure was 156/74 and his pulse was 74. No oxygen saturation level was taken at that time.</p> <p>His next recorded vital signs were taken on 9/25/12 at 7:36 p.m., when he complained of shortness of breath and anxiety and requested to be sent to the emergency room for evaluation. His blood pressure was 170/74, pulse 83, and oxygen saturation rate 92%.</p> <p>During an interview with the Administrator and DoN on 12/19/12 at 11:20 a.m., additional information was requested related to the lack of monitoring of vital signs and oxygen saturation levels following his hospital return on 9/15/12 to ensure the resident's condition was stable and did not deteriorate.</p> <p>During an interview on 12/19/12 at 2:30 p.m., the DoN indicated she had no additional vital sign monitoring or respiratory assessments to provide. The current 8/11/06, policy for "Charting: Alert" was provided by the Director of Nursing on 12/18/12 at 1:00 p.m. The purpose of the policy was to provide a guideline for the clinical documentation process that may be needed following a change in patient condition or status.</p>		<p>Designee will complete daily monitoring, five days a week, of documentation to validate that communication with the resident's Dialysis provider is present in the medical records for each visit. See attachment F.</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p> <p>By what date the systemic changes will be completed? January 18, 2013</p>				

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>The guidelines of the policy indicated the alert charting process includes documentation of a patient's condition that warrants alert charting, the decisions and actions of staff related to the patient's condition and the patient's response to interventions implemented. Situations for alert charting typically include new admission monitoring needs, acute change of patient condition or situations that are expected to resolve or stabilize within 14 days. Some examples include, but are not limited to, new admissions or readmissions.</p> <p>The Alert Charting process includes, but is not limited to, documentation of patient evaluation findings. Documentation related to the alert charting process may include, but is not limited to, patient evaluation pertinent to the condition identified as the acute event such as vital signs.</p> <p>2.) The clinical record for Resident #66 was reviewed on 12/17/12 at 8:38 a.m.</p> <p>Diagnoses for Resident #66 included, but were not limited to, kidney disease, diabetes mellitus, hypertension, and anemia.</p> <p>A health care plan problem, dated</p>				

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>4/26/12 and revised on 10/8/12, indicated Resident #66 had End Stage Renal Disease (ESRD) with risk for complications at the fistula site and requiring dialysis treatments three times a week. Interventions for this problem included, but were not limited to,</p> <p>"Check access site for lack of thrill/bruit, evidences of infection, swelling, or excessive bleeding per facility guidelines and report abnormalities to physician"</p> <p>"Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosages pre-dialysis as needed"</p> <p>"Coordinate dialysis care with dialysis treatment center".</p> <p>A separate binder contained the pre and post assessment/communication forms(weight, vital signs, and any other pertinent information for the care of the resident while at the dialysis center or the facility) between the dialysis treatment center and the facility. The most recent assessment/communication form was dated 9/13/12. The binder was missing approximately 40</p>				

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>assessment/communication forms.</p> <p>During an interview on 12/17/12 at 8:48 a.m., with LPN #3, she indicated the most recent assessment/communication form in the dialysis binder was dated 9/13/12. She also indicated the staff are to be completing the form per policy.</p> <p>3.) Review of the current outpatient dialysis services agreement, provided by the Administrator on 12/19/12 at 9:27 a.m., included, but was not limited to, the following:</p> <p>"... A. Obligations of Nursing Facility and/or Owner...</p> <p>...2. Interchange of Information. The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD Residents...</p> <p>...4. Transport and Referral of ESRD Residents. A. The Nursing Facility shall be responsible for ensuring that the ESRD Residents are medically stable to undergo such transportation and medically suitable to receive treatment at the ESRD Dialysis Unit...."</p>						

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	3.1-37(a)			

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure residents who were dependent on staff for all hygiene needs received service to keep their nails neat, trimmed and clean for 2 of 6 residents who met the criteria for assistance with activities of daily living regarding grooming. (Residents 6 &7)</p> <p>Findings Include:.</p> <p>1.) Resident #7's record was reviewed on 12/19/12, 9:50 a.m.</p> <p>Resident #7's current diagnoses included, but were not limited to, ischemic bowel, cardiomegaly and dementia.</p> <p>Resident #7's record lacked documentation of the resident receiving/refusing showers during the previous six months.</p> <p>Resident #7 had a current, 10/5/12, quarterly, Minimum Data Set</p>	F0312	<p>Tag F312</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Nail care was provided to residents #6 and #7 at the time of the observation.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. The audit included residents that are dependent on care provider for ADL needs. Necessary corrective action was taken as appropriate.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p>	01/18/2013			

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>assessment, which indicated the resident was cognitively impaired and was totally dependent on staff assistance for hygiene and bathing needs.</p> <p>Resident #7 had a current, 12/12, care plan problem/need regarding the resident having a deficit in her activities of daily living due to dementia. The goal for this problem was for the resident to be well groomed daily. Approaches to this problem included, staff to assist with bath/shower as needed and staff to assist daily with hygiene, grooming, dressing, oral care and eating needs.</p> <p>During a 12/12/12, 12:09 p.m. observation, Resident #7 had long, broken, jagged nails with dark residue underneath.</p> <p>During a 12/19/12, 12:45 p.m., observation, Resident #7 was seated in a wheelchair in the Family Tree dining room. Lunch was being served. Resident #7's nails were long, broken and jagged. There was a dark brown residue under her nails. At this time, LPN #2 looked at Resident #7 nails and indicated they needed cleaned and trimmed.</p> <p>During a 12/19/12, 2:20 p.m.</p>		<p>Licensed Nurses have been provided education on the Nail Care Guidelines. See attachment G.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>The Director of Care Delivery or Designee will conduct daily review of residents with assigned showers for completion of grooming needs to include but not limited to Nail Care. See attachment H.</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p> <p>By what date the systemic changes will be completed? January 18, 2013</p>				

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>interview, the Director of Nursing indicated there was no documentation of Resident #7 refusing showers. She additionally indicated Resident #7 should have received nail care during her showers.</p> <p>2.) Resident #6's record was reviewed on 12/17/12 at 4:00 p.m.</p> <p>Resident #6's current diagnoses included, but were not limited to, cerebral palsy, dysphasia and tracheotomy.</p> <p>Resident #6 had a current, 10/19/12, significant change, Minimum Data Set assessment which indicated the resident was cognitively impaired and was totally dependent on staff assistance for all bathing and hygiene needs.</p> <p>Resident #6 had a current, 12/12, care plan problem/need regarding his need for staff assistance with activities of daily living due to cerebral palsy. The goal for this problem was for the resident to be clean and well groomed daily. An approach to this problem was staff to assist with hygiene, grooming, dressing oral care and eating daily.</p>				

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>During a 12/17/12, 3:20 p.m. observation, Resident #6 was seated in a specialized wheelchair in the hallway. His nails were approximately 1/2 inch long with irregular jagged edges.</p> <p>During a 12/19/12, 2:00 p.m. observation, Resident #6 was seated in his specialized wheelchair in the hallway. His nails were long and jagged. Some nails were over 1/2 inch long. At this time, RN #4 looked at Resident #6's nails and indicated they needed trimmed and she would assign the task immediately.</p> <p>During a 12/19/12, 2:20 p.m. interview, the Director of Nursing indicated nail care was generally given to non-diabetic residents in conjunction with their showers.</p> <p>3.1-38(a)(3)(E)</p>				

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
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 ensure a resident with a tracheostomy received respiratory services in a manner to prevent possible transmission of infection for 1 of 1 resident observed with a tracheostomy. (Resident #6)</p> <p>Findings include:</p> <p>The clinical record for Resident #6 was reviewed on 12/17/12 at 4:00 p.m.</p> <p>Diagnoses for Resident #6 included, but were not limited to, cerebral palsy with flexion contractures, dysphagia, jejunostomy tube, left lung lobectomy with tracheostomy, history of healthcare acquired pneumonia.</p> <p>A current health care plan problem for Resident #6, dated 12/23/10 with a</p>	F0328	<p>Tag F328</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Trach/oxygen tubing was changed for resident #6 at the time of observation. The clinical record has been reviewed and updated to include documentation of Trach Tubing changed per guidelines.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. The audit included residents with Oxygen Tubing. Necessary corrective action was taken as</p>	01/18/2013			

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>new target date of 2/23/13, indicated the resident was at risk for respiratory impairment due to his tracheostomy. One approach for this problem was "Trach care per protocol."</p> <p>The clinical record indicated Resident #6 had been hospitalized from 11/22/12 to 12/5/12 with the diagnosis of healthcare acquired pneumonia. The record also indicated the resident had been treated for pneumonia in August and October of 2012 for pneumonia.</p> <p>During observation on 12/17/12 at 3:20 p.m., the following was observed:</p> <p>Resident #6 was sitting up in his specialized wheelchair out in the hallway next to his room. The resident was receiving oxygen via a tracheostomy mask which had a long tubing extending from the mask to the rolling oxygen container. The blue tubing had a plastic collection bag approximately in the middle of the length of tubing. The bag was used to collect excess humidification water present in the tubing. Approximately six inches of the blue tubing and the collection bag were lying on the floor next to the resident's chair.</p>		<p>appropriate.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nurses and Nursing have been provided education on Changing Oxygen Tubing, documentation and infection control practices as it relates to Oxygen tubing maintenance. See attachment I.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>The Director of Care Delivery or Designee will conduct daily monitoring of residents with Oxygen tubing to ensure tubing is stored appropriately in a bag when not in use and to ensure tubing is not touching the floor. See attachment J.</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>				

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>LPN #1 needed to take the resident to his room to administer medications via a Jejunostomy (J) tube. LPN #1 and another unidentified staff member pushed Resident #6 from the hallway into the room dragging the blue oxygen tubing and collection bag across the floor. The bag continued to lie on the floor in the resident's room next to the oxygen container during the observation of the medication administration.</p> <p>During an interview on 12/19/12 at 1:55 p.m., the Infection Control Nurse indicated tracheostomy tubing should not be lying on or dragged across the floor during resident transfers.</p> <p>The November 2012 Medication Administration Record (MAR) indicated "change oxygen tubing and supplies every week on Sundays at night." The dates of 11/4, 11/11, and 11/18 were boxed off for documentation of the tubing being changed. There was no documentation of the tubing being changed on 11/4 and/or 11/11/12.</p> <p>The clinical record lacked any MAR for October 2012 which recorded the tubing changes.</p> <p>During an interview on 12/19/12 at</p>		<p>By what date the systemic changes will be completed? January 18, 2013</p>				

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>11:20 a.m., additional information was requested related to the lack of documentation of the oxygen tubing being changed as noted above. The DoN indicated the facility did not obtain orders for the changing of oxygen tubing. She indicated it was done weekly on Sundays as a nursing measure.</p> <p>During an interview on 12/19/12 at 3:00 p.m., the DoN indicated she had no information to provide related to whether the oxygen tubing changes had been completed on the dates noted above.</p> <p>3.1-47(a)(4)</p>				

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</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 record review and interview, the facility failed to ensure medications were monitored for effectiveness for 2 of 10 residents reviewed for unnecessary medications. (Resident #3 and 153)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #3 was reviewed on 12/17/12 at 8:40 a.m.</p>	F0329	<p>Tag F329 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Physician was contacted and parameters were obtained for collecting Blood Pressure for resident #3. Clinical records were reviewed for resident #153 and updated to include recording of blood pressure and heart rate per the physicians order and facility guidelines prior to administration antihypertensive medication.</p> <p>How other residents having the</p>	01/18/2013	

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>Diagnoses for the resident included, but were not limited to, hypertension, anemia, and diabetes mellitus.</p> <p>The clinical record indicated the resident's speech was garbled on 7/12/12 at 2:45 p.m. Her blood pressure was 184/140. She was sent to the emergency room at that time and was admitted for treatment for multiple health issues including cellulitis and malignant hypertension. She returned to the facility on 7/19/12.</p> <p>Physician's orders, signed 12/5/12, indicated the resident took the following blood pressure related medications:</p> <p>Amlodipine Besylate (an antihypertensive) 5 milligrams tab 1 daily and Lisinopril (an antihypertensive) 10 mg tab 1 daily.</p> <p>The original date of the two medication orders was 7/20/12.</p> <p>The last blood pressure documented in the resident's clinical record was taken on 8/22/12 and was 146/76.</p> <p>During an interview with the DoN on 12/18/12 at 1:20 P.M., additional</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. The audit included residents included residents that are currently receiving antihypertensive medications. Necessary corrective action was taken as appropriate. What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur; Licensed Nurses have been provided education on obtaining vital signs per physician orders and facility guidelines. See attachment K. 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; The Director of Care Delivery or Designee will conduct Medication Administration observations on each shift of licensed nursing staff weekly to include nurses on days, evenings, nights and weekends for a total of 12 observations a week to observe for obtaining and documenting required vital signs. See attachment M. Audit findings will be presented to QA&A committee weekly for 4 weeks</p>				

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>information was requested related to the lack of monitoring of the resident's blood pressure in regards to the need for antihypertensive medications..</p> <p>During an interview on 12/18/12 at 3:00 p.m., the DoN indicated she had no additional blood pressure monitoring information to provide.</p> <p>2. Resident #153's clinical record was reviewed on 12/18/12 at 11:03 a.m. The resident's diagnoses included, but were not limited to, stroke, cardiomyopathy, and delusions.</p> <p>The resident's current physician's orders were signed by the physician on 12/19/12. The resident's orders included, but were not limited to, amlodipine besylate [for high blood pressure] 2.5 mg take 1 by mouth once daily, hydralazine [for high blood pressure] 50 mg take 1 tablet by mouth every 6 hours, lisinopril [for high blood pressure] 2.5 mg by mouth once a day, and metoprolol tartrate [for high blood pressure] 50 mg tablet take 1 tablet by mouth twice a day and hold if the systolic blood pressure is less than 100 or the heart rate is less than 60 beats per minute. The order for metoprolol tartrate originated on 4/11/11.</p>		<p>and monthly thereafter for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process. By what date the systemic changes will be completed? January 18, 2013</p>		

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

	<p>Review of the Medication Administration Records and Nurses Progress Notes lacked an indication of heart rate monitoring and/or blood pressure monitoring on the following dates and times when the metoprolol tartrate was given:</p> <p>11/1/12 at 8:00 p.m. 11/2/12 at 8:00 p.m. 11/3/12 at 8:00 p.m. 11/4/12 at 8:00 p.m. 11/7/12 at 8:00 a.m. 11/9/12 at 8:00 p.m. 11/11/12 at 8:00 a.m. 11/12/12 at 8:00 p.m. 11/13/12 at 8:00 p.m. 11/14/12 at 8:00 p.m. 11/15/12 at 8:00 p.m. 11/13/12 at 8:00 p.m. 11/18/12 at 8:00 p.m. 11/18/12 at 8:00 p.m. 11/19/12 at 8:00 p.m. 11/20/12 at 8:00 p.m. 11/21/12 at 8:00 p.m. 11/24/12 at 8:00 a.m. 11/27/12 at 8:00 p.m. 11/28/12 at 8:00 p.m. 12/3/12 at 8:00 a.m. 12/4/12 at 8:00 a.m. and 8:00 p.m. 12/5/12 at 8:00 a.m. and 8:00 p.m. 12/6/12 at 8:00 a.m. and 8:00 p.m. 12/7/12 at 8:00 a.m.</p> <p>During an interview with the Director of Nursing on 12/19/12 at 2:17 p.m.,</p>			
--	---	--	--	--

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>she indicated she could find no more information related to the monitoring of the medication.</p> <p>3. The current 3/2010, "Medication Administration: Medication Pass" policy was provided by the Director of Nursing on 12/19/12 at 2:16 p.m. The purpose of the policy is to safely and accurately prepare and administer medication according to physician orders and patient needs. The procedure indicated vital signs were to be obtained, if applicable, and the results were to be recorded on the Medication Administration Record.</p> <p>3.1-48(a)(3)</p>				

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the consultant pharmacist identified the lack of vital sign monitoring in regards to medications being given for 2 of 10 residents reviewed for unnecessary medications. (Resident #3 and 153)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #3 was reviewed on 12/17/12 at 8:40 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, hypertension, anemia, and diabetes mellitus.</p> <p>Physician's orders, signed 12/5/12, indicated the resident took the following blood pressure related medications:</p> <p>Amlodipine Besylate (an antihypertensive) 5 milligrams tab 1</p>	F0428	<p>Tag F428</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Physician was contacted and parameters were obtained for collecting Blood Pressure for resident #3.</p> <p>Clinical records were reviewed for resident #153 and updated to include recording of blood pressure and heart rate per the physicians order and facility guidelines prior to administration antihypertensive medication.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. The</p>	01/18/2013			

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>daily Lisinopril (an antihypertensive) 10 mg tab 1 daily</p> <p>The original date of the two medication orders was 7/20/12.</p> <p>The last blood pressure documented in the resident's clinical record was taken on 8/22/12 and was 146/76.</p> <p>During an interview with the DoN on 12/18/12 at 1:20 P.M., additional information was requested related to any pharmacy recommendations having been made in regards to the lack of blood pressure monitoring for Resident #3.</p> <p>During an interview on 12/19/12 at 2:30 p.m., the DoN indicated the pharmacist had reviewed the resident's clinical record on 8/13, 9/10, 10/8, 11/12, and 12/13/12. There were no pharmacy recommendations made on those dates in regards to the lack of vital sign monitoring for Resident #3.</p>		<p>audits included residents that are currently receiving antihypertensive medications. Necessary corrective action was taken as appropriate.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>The Consulting Pharmacist was educated on the facilities guidelines for obtaining Blood Pressure readings for Antihypertensive medications. See attachment L.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>The Director of Care Delivery or Designee will review the Pharmacist recommendations with the attending Physician and act upon per physician's orders. See attachment M.</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p>		

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>2.) Resident #153's clinical record was reviewed on 12/18/12 at 11:03 a.m. The resident's diagnoses included, but were not limited to, stroke, cardiomyopathy, and delusions.</p> <p>The resident's current physician's orders were signed by the physician on 12/19/12. The resident's orders included, but were not limited to, amlodipine besylate [for high blood pressure] 2.5 mg take 1 by mouth once daily, hydralazine [for high blood pressure] 50 mg take 1 tablet by mouth every 6 hours, lisinopril [for high blood pressure] 2.5 mg by mouth once a day, and metoprolol tartrate [for high blood pressure] 50 mg tablet take 1 tablet by mouth twice a day and hold if the systolic blood pressure is less than 100 or the heart rate is less than 60 beats per minute. The order for metoprolol tartrate originated on 4/11/11.</p> <p>Review of the Medication Administration Records and Nurses Progress Notes lacked an indication of heart rate monitoring and/or blood pressure monitoring on the following</p>		<p>By what date the systemic changes will be completed? January 18, 2013</p>		

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>dates and times when the metoprolol tartrate was given:</p> <p>11/1/12 at 8:00 p.m. 11/2/12 at 8:00 p.m. 11/3/2 at 8:00 p.m. 11/4/12 at 8:00 p.m. 11/7/12 at 8:00 a.m. 11/9/12 at 8:00 p.m. 11/11/12 at 8:00 a.m. 11/12/12 at 8:00 p.m. 11/13/12 at 8:00 p.m. 11/14/12 at 8:00 p.m. 11/15/12 at 8:00 p.m. 11/13/12 at 8:00 p.m. 11/18/12 at 8:00 p.m. 11/18/12 at 8:00 p.m. 11/19/12 at 8:00 p.m. 11/20/12 at 8:00 p.m. 11/21/12 at 8:00 p.m. 11/24/12 at 8:00 a.m. 11/27/12 at 8:00 p.m. 11/28/12 at 8:00 p.m. 12/3/12 at 8:00 a.m. 12/4/12 at 8:00 a.m. and 8:00 p.m. 12/5/12 at 8:00 a.m. and 8:00 p.m. 12/6/12 at 8:00 a.m. and 8:00 p.m. 12/7/12 at 8:00 a.m.</p> <p>Review of the pharmacy consultant reports indicated the pharmacist had reviewed resident #153's medications on 11/20/12 and 12/13/12 with no recommendations related to the monitoring of the resident's heart rate and blood pressure.</p>						

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>During an interview with the Director of Nursing on 12/19/12 at 2:17 p.m., she indicated she could find no more information related to the monitoring of the medication.</p> <p>3. The current 5/2010, policy for "Medication Regimen Review" for the Pharmacist medication review was provided by the Director of Nursing on 12/19/12 at 2:30 p.m. The procedure indicated the Consultant Pharmacist would conduct a medication regimen review and report any irregularities in the medication regimen.</p> <p>3.1-25(i)</p>				

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 12/19/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease 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, record review, and interview, the facility failed to</p>	F0441	Tag F441	01/18/2013			

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>ensure the nursing staff washed their hands when necessary and provided care in a manner to prevent the possible transmission of disease and infection for 1 of 1 LPN observed administering medications to 1 of 1 resident with a jejunostomy tube (Resident #6) and failed to ensure a resident with a tracheostomy received respiratory services in a manner to prevent possible transmission of infection for 1 of 1 resident observed with a tracheostomy. (Resident #6)</p> <p>Findings include:</p> <p>The clinical record for Resident #6 was reviewed on 12/17/12 at 4:00 p.m.</p> <p>Diagnoses for Resident #6 included, but were not limited to, cerebral palsy with flexion contractures, dysphagia, jejunostomy tube, left lung lobectomy with tracheostomy, and history of healthcare acquired pneumonia.</p> <p>During observation on 12/17/12 at 3:20 p.m., the following was observed:</p> <p>Resident #6 was sitting up in his specialized wheelchair out in the hallway next to his room. The resident was receiving oxygen via a</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>LPN #1 was educated on hand hygiene, medication administration of meds via j tube and oxygen tubing per facility guidelines.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</p> <p>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. The audits included residents that are on oxygen therapy and receive medications via j tube route. Necessary corrective action was taken as appropriate.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</p> <p>Licensed Nurses will be educated on guidelines on Hand Hygiene and Oxygen tubing placement per facility guidelines. See attachment N.</p> <p>Licensed Nurses will be educated</p>		

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>tracheostomy mask which had a long tubing extending from the mask to the rolling oxygen container. The blue tubing had a plastic collection bag approximately in the middle of the length of tubing. The bag was used to collect excess humidification water present in the tubing. Approximately six inches of the blue tubing and the collection bag were lying on the floor next to the resident's chair.</p> <p>LPN #1 needed to take the resident to his room to administer medications via a Jejunostomy (J) tube. LPN #1 and another unidentified staff member pushed Resident #6 from the hallway into the room dragging the blue oxygen tubing and collection bag across the floor. The bag continued to lie on the floor in the resident's room next to the oxygen container during the observation noted below.</p> <p>LPN #1 provided privacy and prepared to given Resident #6 his liquid medication via his J tube. LPN #1 washed her hands. She then looked for the syringe used to administer the med into the tube. None was present in the room. She then left the room and went to obtain a new syringe.</p> <p>When she returned to the room with</p>		<p>on proper hygiene during medication pass that involves administering medication via j tube. See attachment N.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</p> <p>The Director of Care Delivery or Designee will conduct Medication Administration observations on residents that receive medications via J-tube. The Director of Care Delivery or Designee will conduct Medication Administration observations on each shift of licensed nursing staff weekly to include nurses on days, evenings, nights and weekends for a total of 12 observations a week to ensure proper technique and follow up is in place to prevent the spread of infection. Observations will include hand washing during administration of meds via j tube route, clean technique and placement of barriers for equipment used during med pass. See Attachment O.</p> <p>The Director of Care Delivery or Designee will conduct daily review of residents with Oxygen tubing to ensure tubing is stored appropriately in a bag when not in use and to ensure tubing is not touching the floor. See</p>		

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>the new syringe, she did not wash her hands. She opened the new syringe package and donned gloves. She removed the plastic cap from the end of the syringe and placed it the plug end of the tubing that she had disconnected from his J tube. When she had finished giving the medication and flushing the tube, reconnected his feeding tube into the J tube port. She placed the plastic cap, which had covered the tube feeding plug, onto a metal protrusion sticking out at the top of the pole holding the bag of feeding solution to be used for future medication administration.</p> <p>LPN #1 placed the outer portion of the feeding syringe in the bottom of the sink and indicated she needed to rinse it out. She picked up the inner cylinder/plunger which was lying on the cabinet top next to the sink, rinsed off the outer syringe and put them both into the plastic bag they had been packaged in for future use. and put the inner cylinder and the outer portion of the large syringe into the plastic bag that it had been packaged in for use again when needed. She then dropped the package on the floor and indicated she would now have to throw it away. She removed her gloves and washed her hands.</p>		<p>attachment O.</p> <p>Audit findings will be presented to QA&A committee weekly for 4 weeks and monthly thereafter for a minimum of six months. QA&A committee will review findings and determine need for further monitoring and/or education per the QA&A process.</p> <p>By what date the systemic changes will be completed? January 18, 2013</p>		

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 12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

	<p>During an interview with LPN #1 on 12/17/12 at 3:40 p.m., LPN #1 indicated she should have washed her hands again when she returned to the room prior to giving the medication. She indicated she thought it was a facility practice to place the tubing cap on the metal protrusion at the top of the pole to be ready for future use.</p> <p>During an interview on 12/19/12 at 1:55 p.m., the Infection Control Nurse indicated a clean barrier should be set up to place supplies on during medication administration to residents with jejunostomy tubes. She indicated the syringes should never be placed in the sink or on the counter tops and the cap should not be placed on the metal protrusion on the feeding pole. She indicated tracheostomy tubing should not be lying on or dragged across the floor during resident transfers.</p> <p>The current 12/09, "Hand Hygiene" policy and procedure was provided by the Director of nursing on 12/18/12 at 1:00 p.m. The purpose of the policy was to decrease the spread of infection. The policy indicated the hands were to be washed or an alcohol-based hand rub was to be used before and after applying and</p>			
--	---	--	--	--

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 12/19/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>removing gloves and after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>3.1-18(l)</p>				