

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155247	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2015
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227
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F 0000 Bldg. 00	<p>This visit was for Investigation of Complaints IN00174565 and IN00175684.</p> <p>Complaint IN00174565 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250.</p> <p>Complaint IN00175684 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 17 & 18, 2015</p> <p>Facility number: 000151 Provider number: 155247 AIM number: 100284060</p> <p>Census bed type: SNF: 29 SNF/NF: 82 Total: 111</p> <p>Census payor type: Medicare: 14 Medicaid: 58 Other: 39 Total: 111</p> <p>Sample: 3</p>	F 0000	<p>Legal Disclaimer: This Plan of Correction constitutes the center's Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p> <p>Facility respectfully requests a paper/ desk review for validating compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0250 SS=D Bldg. 00	<p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure discharge planning for funeral services were provided for 1 of 3 residents reviewed for discharge planning in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 6/17/15 at 11:30 a.m. Diagnoses for Resident #B included, but were not limited to, lung cancer with metastasized brain cancer.</p> <p>The resident was admitted to the facility on 10/18/13. The facility's Admitting RECORD (face sheet) lacked documentation of Mortuary services for Resident #B. Additionally, the current face sheet (no date) being utilized by the facility lacked documentation for funeral</p>	F 0250	<p>Deficiency ID: F _ 250</p> <p>Completion Date: 7/15/2015 12:00:00 AM</p> <p>Plan of Correction Text:</p> <p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; Resident B was discharged from facility. No other residents were identified as being affected by the deficient practice.</p> <p>II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken; All current Residents will be audited for discharge planning for funeral services. Those residents, who have not provided facility with information regarding funeral</p>	07/15/2015

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	<p>arrangements.</p> <p>A social service note dated 11/22/14, indicated Resident #B was a Full Code (life saving measures) and on 12/3/14, the resident's status had been changed to DNR (do not resuscitate).</p> <p>The record lacked documentation Social Services assisted the resident with discharge planning for funeral services.</p> <p>A hospice note, dated 1/15/15, indicated funeral home arrangements had not been finalized.</p> <p>During an interview with the Director of Nursing on 6/17/15 at 4:30 p.m., discharge planning documentation for funeral services was requested.</p> <p>During an interview on 6/18/15 at 8:45 a.m., with the Administrator, she indicated no further documentation regarding discharge planning could be found.</p> <p>This Federal tag relates to complaint IN00174565.</p> <p>3.1-34(a)</p>		<p>services, will be contacted by Social Services for assistance with discharge planning for funeral services.</p> <p>III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; Social Services Department will be in-serviced by 7/1/15 by Administrator, regarding the documentation of assisting residents or responsible parties with discharge planning for funeral services. Chart audits of all new admissions will occur during the Eagle Room Meeting (M-F daily QA process) Audits will occur 5 times weekly for 4 weeks then monthly thereafter. The Medical Records designee and /or their designee will check the documentation of discussion of discharge planning for funeral services during Chart audits. Any lack of documentation and or no listing of a funeral service will be corrected by social services with documentation of a discussion of discharge planning related to funeral services.</p> <p>IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place; Results of audits will be reviewed at QA Committee during monthly QA Meetings. Reporting of findings will continue until three (3) months of</p>	

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			zero negative findings. Any additional action needed will be determined by the Administrator ongoing.		