

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  09/10/2013
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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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F000000	<p>This visit was for the Investigation of Complaints IN00133415, IN00133542, and IN00136177.</p> <p>Complaint IN00133415 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00133542 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00136177 - Unsubstantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 9 &amp; 10, 2013</p> <p>Facility number: 000151 Provider number: 155247 AIM number: 100284060</p> <p>Survey team: Diana Zgonc, RN-TC</p> <p>Census bed type: SNF: 23 NF: 40 SNF/NF: 59 Total: 122</p> <p>Census payor type:</p>	F000000		

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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	<p>Medicare: 23 Medicaid: 61 Other: 38 Total: 122</p> <p>Sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 13, 2013; by Kimberly Perigo, RN.</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a wandering resident had adequate supervision to keep him from disrobing and roaming in and out of other residents' rooms for 1 of 5 residents reviewed for wandering in a sample of 5. (Resident #C, #B, &amp; #F)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 9/9/13 at 10:25 A.M.</p> <p>Diagnoses for Resident #C included, but were not limited to anoxic brain injury, dementia and non-organic psychosis.</p> <p>A nurses note dated 7/30/13 at 00:22 (12:22 A.M.), indicated Resident #C had 2 episodes of pulling his pants down and walking out into the hallway.</p> <p>A nurses note dated 7/30/13 at 23:07 (11:07 P.M.), indicated the resident went into the room across the hall</p>	F000323	<p>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 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.F323 Free of Accident Hazards/Supervision/Devices; It is the practice of Manor Care Indy South to provide a resident environment that remains as free of accident as is possible.What corrective action will take place for those residents found to be affected by the deficient practice? Resident #C no longer resides in the facility.Residents #B and #F were assessed by Social Services to assure psychosocial needs have been addressed. How other residents having the</p>	10/10/2013

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	<p>and laid in the resident's beds. He became uncooperative when asked to leave the room.</p> <p>A nurses note dated 8/1/13 at 14:18 (2:18 P.M.,) indicated the resident was up wandering into other resident's rooms. He attempted to kick a CNA and refused to be checked for incontinence.</p> <p>A nurses note dated 8/2/13 at 9:00 A.M., indicated the resident had been wandering in and out of other residents' room and laying on other residents' beds. The resident is showing signs of agitation with staff. The nurse was summoned by another nurse to assist getting the resident out of another resident's bed. The resident grabbed the nurses hand and squeezed hard and would not release his grip for several seconds.</p> <p>A nurses note dated 8/2/13 at 23:37 (11:37 P.M.), indicated the resident had wandered into an adjacent room twice this shift.</p> <p>A nurses note dated 8/14/13 at 23:00 (11:00 P.M.), indicated the resident was observed with increased restless behavior with verbal aggression and sexual undertones in addition to the intrusive wandering. Multiple</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action will be taken?Care plans of current residents who have had current episodes of wandering or have a history of unsafe wandering behavior will be reviewed to assure appropriate behavioral management interventions are in place to assure adequate supervision.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?Facility staffs will be in-serviced on our Wandering Patient Practice Guide; specifically to include initiation of 1:1 staff monitoring of a resident when there is escalation in wandering behaviors. How will the corrective actions be monitored to ensure they do not occur again?Anytime a resident demonstrates unsafe wandering behaviors or when unsafe wandering event occurs, resident will be placed on 1:1 staff monitoring. IDT will assess resident and document a summary of the resident's condition, review plan of care, and add interventions as appropriate. A QAA monitoring tool will be completed by ADNS/designee on staff's response to a resident exhibiting unsafe wandering behaviors with the expectation that resident is immediately removed from the</p>	

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	<p>nonpharmacological interventions were attempted and failed to redirect the resident or decrease the behaviors.</p> <p>A nurses note dated 8/18/13 at 6:45 A.M., indicated the resident was seen ambulating into another patient's room.</p> <p>1) The record for Resident #B was reviewed on 9/9/13 at 9:50 A.M.</p> <p>Diagnoses for Resident #B included but were not limited to hypertension, chronic obstructive pulmonary disease, osteoporosis, depression, and history of deep vein thrombosis.</p> <p>The resident's quarterly Minimum Data Set (MDS) assessment dated 6/22/13 indicated the resident's BIMS (brief interview of mental status) score was "15" (cognitively intact).</p> <p>During an interview with Resident #B on 9/9/13 at 1:20 P.M., she indicated Resident #C wanders in and out of other residents' rooms, getting in the beds and eating their food. She also indicated she was afraid of the resident.</p> <p>2) The record for Resident #F was reviewed on 9/9/13 at 11:00 A.M.</p>		<p>unsafe area and placed on 1:1 staff monitoring. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee weekly. By what date will the changes occur? 10/10/2013</p>		

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	<p>Diagnoses for Resident #F included, but were not limited to hemiplegia, anxiety, dysphagia, cerebral vascular accident, and hypertension.</p> <p>The resident's quarterly Minimum Data Set (MDS) assessment dated 8/29/13, indicated the resident's BIMS (brief interview of mental status) score was "15" (cognitively intact).</p> <p>During an interview with Resident #F on 9/9/13 at 1:00 P.M., she indicated Resident #C comes into her room and gets in her roommates bed or just stands at the end of her bed and "stares at me. He doesn't say or do anything but he scares me." He was in here a couple of days ago.</p> <p>During an interview with the Social Worker on 9/9/13 at 12:15 P.M., he indicated this is a difficult case, because the POA (power of attorney) doesn't want him moved even though she knows he's not appropriate for this facility. We've been working with the family for some time to place him somewhere else.</p> <p>During an interview with the Director of Nursing on 9/9/13 at 2:25 P.M., she indicated no other resident's have ever indicated they were afraid of</p>			

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	<p>Resident #C and we have scheduled him to have one on one supervision.</p> <p>During the exit conference on 9/10/12 at 2:00 P.M., the Administrator indicated Resident #C will have one on one supervision until he is moved to an appropriate facility.</p> <p>This Federal tag relates to Complaints IN00133415 and IN00133542.</p> <p>3.1-45(a)(2)</p>			