

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243
--	---

(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
F 000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on February 9, 2015.</p> <p>Survey date: March 24, 2015.</p> <p>Facility number: 000115 Provider number: 155208 AIM number: 100291080</p> <p>Survey Team: Tammy Forthofer, RN - TC Rita Bittner, RN Julie Dover, RN</p> <p>Census bed type: SNF/NF: 57 Residential: 7 Total: 64</p> <p>Census payor type: Medicare: 10 Medicaid: 38 Other: 9 Total: 57</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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: 155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243
--	---

(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
F 315 SS=D Bldg. 00	<p>Quality review completed on March 26, 2015 by Brenda Buroker, RN.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to provide bladder irrigations for Foley catheter care for 1 of 3 residents reviewed who met the criteria for Foley catheter use. (Resident #14)</p> <p>Findings include:</p> <p>The clinical record was reviewed for Resident #14 on 3/24/2015 at 1:00 P.M.</p> <p>The physician's order, dated 11/12/2014, indicated Resident #14 was to receive Acetic Acid 0.25% bladder irrigations on Mondays and Fridays.</p>	F 315	<p>1. Per interview with Resident #14 (BIMs score of 15), the resident stated that she is aware of the schedule by which irrigations are performed and has no recollection of a nurse failing to perform the ordered irrigation. The nurse responsible for the omitted documentation of three separate irrigations was contacted, but stated she could not recall if the ordered irrigations were completed on the dates in question. The nurse no longer works at the facility. Resident #14 receives ordered irrigations and the same is documented, Resident #14 exhibits no signs/symptoms of urinary tract infection.2. In an effort to identify any other residents potentially</p>	04/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2015	
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243			
(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 Medication Administration Record (MAR) for Resident #14 indicated the flushes were not completed on 3/16/2015, 3/20/2015, and 3/23/2015.</p> <p>During an interview on 3/24/2015 at 2:28 P.M., the Director of Nursing (DON) indicated she did not know why the bladder irrigations were not done on 3/16/15, 3/20/15, and 3/23/15. The DON indicated there was no documentation verifying why the treatments were not completed in the Treatment Administration Record, Nursing Notes, or MAR.</p> <p>During an interview on 3/24/2015 at 2:48 P.M., the Assistant Director of Nursing (ADON) indicated there was no documentation in the nursing notes pertaining to the missed Acetic Acid bladder irrigations which were ordered by the physician to be done on 3/16/2015, 3/20/2015, and 3/23/2015. The ADON indicated the Acetic Acid bladder irrigations should have been completed on every Monday and Friday.</p> <p>During an interview on 3/24/2015 at 3:04 P.M., Resident #14 indicated she had never refused a bladder irrigation. The resident indicated the bladder flushes were necessary to prevent urinary tract infections.</p>		<p>affected, the orders and corresponding nursing documentation of services performed were reviewed for all residents with anchored catheters. Care provided in accordance with physicians' orders was confirmed. 3. In an effort to ensure ongoing compliance with the provision of ordered treatments, licensed nurses will receive Directed Inservice Training, (Attachment A), specifically addressing bladder irrigations of foley catheters and documentation thereof, (Attachment B). Said inservice training will be provided by Rebecca Bertle, RN, BSN, Regulatory Affairs Director, Hoosier Owners and Providers for the Elderly. Any licensed nurse who is unable to attend the scheduled inservice training will be required to meet with the DON/designee and complete the required training, utilizing a videotaped version of the original training, prior to their next tour of duty. 4. As a means of quality assurance, the DON/designee shall be responsible to monitor those residents with anchored catheters daily on scheduled days of work to ensure all ordered care and services are provided as per order and plan of care, (Attachment C). Should an omission or concern be identified, investigation will be conducted immediately and necessary corrective action taken, to include</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2015
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243		
(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	
R 000	<p>The quarterly Minimum Data Set Assessment (MDS), dated 2/05/2015, indicated Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15, signifying the resident was alert and oriented.</p> <p>Resident #14's Urinary Incontinence Care Plan was revised on 2/19/2015 and indicated the resident was receiving Palliative Care for terminal rectal cancer and urinary retention. The resident was monitored for signs and symptoms of infections and referred to the urologist as needed.</p> <p>This deficiency was cited on 2/9/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-41(a)(2)</p>		<p>re-education and disciplinary action, as warranted. Results of ongoing monitoring and any corrective actions taken shall be reported to the QA Committee on an, at least, quarterly basis. Monitoring shall continue until the QA Committee has deemed sufficient evidence of 100% continued compliance with provision of bladder irrigations as per physicians' orders.5. The above corrective actions will be completed by April 7, 2015.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2015
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243		
(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	
Bldg. 00	Hanover Nursing Center was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Survey.	R 000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.		