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 07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	8549 S MADISON AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	This visit was for Investigation of Complaints IN00110794 and IN00111318. Complaints: IN00110794 Substantiated, Federal/State deficiencies related to the allegations are cited at F157, F309, F323, F329, F425 and F514. IN00111318 Substantiated, Federal/State deficiency related to the allegation is cited at F425. Survey Dates: July 3, 5 & 11, 2012 Facility Number: 000151 Provider Number: 155247 Aim Number: 100284060 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 40 SNF/NF: 76 Total: 116	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Census Payor Type: Medicare: 19 Medicaid: 56 Other: 41 Total: 116 Sample: 5 These deficiencies also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/12/12 Cathy Emswiller RN			

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F0157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview the facility failed to ensure a resident's physician was kept current on a resident's	F0157	It is the practice of Manor Care Indy South to contact a patient's physician and Family when the patient has an accident involving injury and has the potential for requiring physician intervention	08/07/2012

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	condition, in that when a resident fell and sustained a head injury and later had a change of condition which included massive bleeding, nausea/vomiting, complaints of headache and inability to verbalize, the licensed nurse [employee #8] failed to continue to update the physician for emergent intervention. The licensed nurse [employee #8] waited over four hours before transferring the resident to the local hospital emergency room for evaluation and/or treatment, at which time the resident arrived at the hospital with pupils pinpoint and fixed and was assessed with a large subdural hematoma which resulted in the resident's death. This deficient practice affected 1 of 2 residents reviewed for falls and who sustained a head injury which required additional physician intervention in a sample of 5. [Resident "A"]. Findings include:		and when a patient has a significant change in physical, mental, or psychosocial status. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Resident # A has been discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Like residents are those who have had an accident involving an injury and have the potential for physician intervention. Nursing staff will notify Physician and Family immediately when a resident fall results in head injury and or there is an accident involving injury; This notification will be documented in the progress note and verified by ADNS or designee at the time of the fall. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed nursing staff have been in-serviced on the need to notify physician and Family if the patient has an accident involving injury and has the potential for requiring physician intervention and when a patient has a significant change in physical, mental, or psychosocial status. **How the corrective action will be monitored to**	

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	The record for Resident "A" was reviewed on 07-03-12 at 10:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, depressive disorder, scoliosis, hypertension and a history of urinary tract infections. These diagnoses remained current at the time of the record review. The hospital discharge summary, dated 06-19-12, indicated the resident had acute delirium, cardiomegaly and was identified as a fall risk. The hospital fall scale, dated 06-19-12, prior to admission to the facility indicated "confusion, provide regular reality orientation, give directions one step at a time to allow time for comprehension, purposeful rounding every 30 minutes and document check, DO NOT leave resident unattended in bathroom or on bedside commode, attempt room placement close to nursing station, use bed check alarms and chair alarm." The preadmission Physician		**ensure the deficient practice does not reoccur?** ADNS or designee will monitor resident falls with injury to assure immediate notification of physician and family. 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 monthly. **Date to be completed** 8/7/2012	

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	Certification for Long Term Care Services, 450B assessment, dated and signed by the physician on 06-19-12, indicated the resident was "confused/disoriented, and high fall risk due to confusion and unsteady gait." The resident record indicated the following incidents. "06-20-12 at 8:11 a.m. Found resident laying supine position on bedside mat. Dx. [diagnoses] Alzheimer's, unable to follow direction to use call light even though given frequent reminders and cueing since admission. Resident may have been attempting to get to toilet <sic>. No injury found. Neuro checks WNL [within normal limits]." The resident's physician was notified. "06-20-12 11:30 p.m. Writer went to check on resident and found resident sitting at the edge of the bed with a raised area on the upper right eye, slightly purple in color.			

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	Area measuring 9 cm [centimeters] by 7 cm. Resident states ... fell early, when going to kitchen to get a drink and hit his <sic> head on floor ... " "Ice pack was applied to the raised area on the upper right eye, helpful." The resident's physician was notified. The nurses notes, documented by Licensed Nurse employee #8, and dated 06-22-12 at 4:41 a.m., indicated, "Note Test: F/U [follow up] continues for fall. No new injuries noted. Scant amount of blood noted in toilet and brief dx. [diagnosis] hemorrhoids. Vital sign <sic> @ [at] 12 a.m. [blood pressure]137/84, [pulse] 89, [respirations] 18, T [temperature] 98.2, O2 [oxygen saturation level] 94% ra [room air] resident denies pain early at start of shift. At 2:30 a.m. resident c/o [complained of] headache, lethargy, diaphoretic. BP [blood pressure] 98/66, [pulse] 75, [respirations] 16, O2 saturation 94% RA. Resident unable to swallow prn [as needed] Tylenol			

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	c/o headache. MD [Medical Doctor] notified, no new order at this time." Interview on 07-06-12 at 5:15 a.m., Licensed Nurse employee #8 indicated the following; "I came in and got report and was told to watch [resident] because [resident] kept trying to get up. The CNA [certified nurses aide employee #9] called me in. He said [name of resident] was in the bathroom and is bleeding - it was hemorrhoids. There was blood in the toilet. [Name of resident] was sitting on the toilet. The CNA [employee #8] put [resident] back to bed and the vital signs were ok. [Resident] slept. The CNA called after a few hours and said 'I need you in here' and I went to the room. [Resident] was sitting on the side of the bed] and said [resident] had a headache. I checked the vital signs and they were different. The blood pressure was 98 over something, but the O2 and respirations were ok. [Resident] was sweating and			

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	temperature was spiking. I got Tylenol and [resident] took 1/2 of it. I waited a little bit and then called the doctor. I called the office [in regard to the physician's office] and the lady, the nurse, gave me an order for Tylenol suppository. She [the lady nurse] asked me - I told condition and asked if I could send [resident] out. She said since the resident is DNR [Do Not Resuscitate] I cannot give you an order to send [resident] out. She told me to ask the family. I called the Unit Manager [Licensed Nurse employee #3] before the family call. She [the Unit Manager] told me since the resident was a DNR call, and ask the family what they want. She asked me if I called the Doctor and I said 'yes' and I told her the office [lady nurse] wouldn't give me an order to send the resident out since the resident is a DNR. I gave the Tylenol suppository. When I talked to [resident] she tried to respond but couldn't. I waited for family to call. When I talked to [name of			

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	Unit Manager] she told me to do as the family and Doctor say and 'there's nothing we can do.' [Name of resident] didn't have any other bruises other than what was on the face." Interview on 07-06-12 at 5:45 a.m. CNA employee #9 indicated, "The evening shift CNA told me [resident] had fallen and was constantly getting up without supervision and that [resident] was a fall risk. That is when all the craziness started. The call light came on because the roommate needed to go to the bathroom. [Resident "A"] was already on the toilet. There was massive blood and clots in the toilet, almost like when a women has a period [menses]. Every time I changed [resident] there were clots in the brief [incontinent]. They [in reference to the nurses] told me it was just hemorrhoids and they gave me a cream to put on the hemorrhoid. I was in that room a lot for both [resident] and the			

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	roommate. The roommate called for assistance to go to the bathroom and when I went in there was a trail of blood from the bathroom to the bed. [Resident "A"] was half on the bed. There was blood on the sheets and I had to change [resident], the bed and then pulled [resident] up in bed. [Name of Licensed Nurse employee #8] helped me. Then later [name of CNA employee#10] came down to help me with call lights. She went to help [name of Resident "A"] roommate - that's when I could see that [Resident "A"] was not normal. I got [name of Licensed Nurse employee #8] to come down. There was bruising on [resident] face and arms - and didn't look good. [Name of CNA employee #10] sat with [resident] and I went to get [name of Licensed Nurse employee #8] again. [Name of resident] was laying on stomach and shivering." Interview on 07-06-12 at 5:55 a.m. CNA employee #10 indicated, I was working on TCU [Transitional			

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	Care Unit]. I walked down here [in reference to the area where CNA employee #9] was working. She [CNA employee #9] was taking care of [name of resident "A"]. I had [Resident "A"] 2 days earlier and when I walked in [name of Resident "A"] was naked and lying face down on the bed. [Resident "A"] was dry heaving and there was a lot of saliva under [resident]. [Resident "A"] was burning up. [Resident "A"] was shaking like having a seizure. I told [name of Licensed Nurse employee #8] to check [resident] out. [Resident] told me 'something's wrong, my head hurts, something's wrong.' [Resident] was drooling mucousy saliva. I told [name of Licensed Nurse employee #8] that if [resident] says something's wrong, then something is wrong [emphatic]. The first night I had [Resident "A"] had a fall. [Resident] didn't know where [resident] was at, confused and anxious. The complete side of the face was purple black and blue. It			

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	looked like someone beat [resident] up." The record indicated the resident was transported to the local area hospital at approximately 7:15 a.m. on 06-22-12, over 4 hours after the resident displayed signs and symptoms of a change in condition and lacked any additional assessments of the resident's condition or decline since the original noted decline in condition at 2:30 a.m. The local area hospital Emergency room record, reviewed on 07-03-12 at 2:00 p.m., indicated the resident had "intracranial hemorrhage, subdural hemorrhage and altered mental status with increase respiratory rate and fever, pupils pinpoint and non reactive [to light], with extensive bruising noted to the right side of head." The hospital Discharge Summary, dated 06-23-12 indicated the resident was "admitted from			

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	nursing home after a fall and acute loss of consciousness and found to have a large subdural hematoma at admission." The record further indicated the resident was then admitted to the hospital Hospice, where on 06-24-12 at 2250 [10:50 p.m.] the resident expired. Further interview on 07-06-12 at 6:15 a.m., Licensed Nurse employee #8 indicated she did not contact the physician when the resident was found with copious amounts of saliva and inability to communicate and continued clots of blood found in the incontinence brief when changed. The facility "Clinical Services FYI [for your information] - Post Fall Evaluation, dated March 2011, provided by the Interim Director of Nurses, indicated the following" "Falls are a common source of patient injury. A comprehensive clinical evaluation by the nurse supervisor is important to			

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	determine the extent of injury and the need for additional intervention. The licensed nurse is responsible for completing this evaluation and reporting changes in condition to the attending physician whenever any symptom, sign or apparent discomfort is sudden in onset, a marked change in relation to usual symptoms or unrelieved by initial interventions." This Federal deficiency relates to Complaint IN00110794. 3.1-5(a)			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. Based on record review and interview the facility failed to ensure a resident received prompt medical intervention, in that when a resident had a fall and sustained a head injury which resulted in change in condition, the nurse failed to provide a resident with emergent care. The resident displayed a change in condition which included massive bleeding, nausea/vomiting, complaints of headache and inability to verbalize, and the licensed nurse [employee #8] waited over four hours before sending the resident to the local hospital emergency room for evaluation and/or treatment. The resident arrived at the hospital with pupils pinpoint and fixed and was assessed with a large subdural	F0309	It is the practice of Manor care Indy South to provide all residents with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Resident # A has been discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Residents who fall have the potential for a significant change in condition that would require continued assessment and or emergent care. Residents who experience an injury or a fall resulting in injury and or change in condition will be provided with necessary care and services including an immediate evaluation by a Licensed nurse. The Physician and Family will also be notified and any new orders will be	08/07/2012

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	hematoma which resulted in the resident's death. This deficient practice effected 1 of 2 residents who sustained a head injury as a result of a fall and had a change of condition, in a sample of 5. [Resident "A"] Findings include: The record for Resident "A" was reviewed on 07-03-12 at 10:30 a.m. Diagnoses included but were not limited to, Alzheimer's disease, depressive disorder, scoliosis hypertension and a history of urinary tract infections. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 06-19-12 after a brief hospitalization for a urinary tract infection and sepsis. The hospital discharge summary, dated 06-19-12 indicated the resident had acute delirium, cardiomegaly and was identified as		implemented. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed nursing staff have been in-serviced on the following: Ø Evaluation and Assessment of a patient's significant change in condition post fall or injury: Physical, Mental or Psychosocial status Ø Post Fall Evaluation, including emphasis on the use of anticoagulants and risk with head injury; notification of Physician for clarification of continued use after a fall. Ø Any circumstance could lead to a patient being sent to hospital based on the decision of the Physician, Family, or Clinical Judgment of the Nurse if unable to talk to Attending Physician, Family or Medical Director. Ø Neuro Check Evaluation post fall **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** QAA monitoring tool will be completed by ADNS/Designee on patient injury or post fall evaluation and anticoagulant usage in patients with falls. 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	

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	a fall risk. The hospital fall scale, dated 06-19-12, prior to admission to the facility indicated "confusion, provide regular reality orientation, give directions one step at a time to allow time for comprehension, purposeful rounding every 30 minutes and document check, DO NOT leave resident unattended in bathroom or on bedside commode, attempt room placement close to nursing station, use bed check alarms and chair alarm." The preadmission Physician Certification for Long Term Care Services, 450B assessment, dated and signed by the physician on 06-19-12 indicated the resident was "confused/disoriented, and high fall risk due to confusion and unsteady gait." The admission physician orders dated 06-19-12 included Plavix [a platelet inhibitor] 75 mg daily and Lovenox 30 mg [milligrams] per 0.3 ml [milliliters] sq [subcutaneous] q [every] HS		reviewed by QAA committee monthly. **Date to be completed** 8/7/2012	

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	[bedtime]. The Initial Clinical Assessment, dated 06-19-12 indicated the resident was "severely cognitively impaired, had difficulty in focusing attention, with disorganized thinking which "fluctuates (comes and goes in severity), with shortness of breath, a history of falls, an unsteady gait, and required frequent reminders and cueing due to demenia <sic> with alzhemiers. Frequent attempts to get up due to confusion, frequently re-oriented to facility protocol, call light use and safety issues." The resident record indicated the following incidents. "06-20-12 at 8:11 a.m. Found resident laying supine position on bedside mat. Dx. [diagnoses] Alzheimer's, unable to follow direction to use call light even though given frequent reminders and cueing since admission. Resident may have been attempting			

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	to get to toilet <sic>. No injury found. Neuro checks WNL [within normal limits]." The nurses started the neurological evaluation flow sheet on 06-20-12 at 5:30 a.m. The directions at the top of this form instructed the nursing staff to "complete neurological evaluation with vital signs initially, then every 30 minutes times 4, then every hour times, 4, then every 8 hours times 9 (72 hours). More frequent evaluation may be necessary. More frequent evaluations may be necessary. Use both sides of this form and additional forms if necessary. Complete episodic charting for at least 72 hours including any pertinent evaluation findings related to the neurological evaluation. Review the most recent evaluation on the medical record and notify the Physician of any changes from previous evaluation." "06-20-12 11:30 p.m. Writer went to check on resident and found			

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	resident sitting at the edge of the bed with a raised area on the upper right eye, slightly purple in color. Area measuring 9 cm [centimeters] by 7 cm. Resident states ... fell early, when going to kitchen to get a drink and hit his <sic> head on floor ... " "Ice pack was applied to the raised area on the upper right eye, helpful." The Licensed Nurses continued the neurological checks as directed including when the resident was found with the raised area to the right side of the head. During interview on 07-05-12 at 10:30 a.m. the Unit Manager Licensed Nurse employee #3 indicated the nursing staff "should have started the neuro checks over once the discovered the bump." The Rehabilitation progress notes, dated 06-21-12 indicated the resident was "seen today for skilled physical therapy. Pt had a fall on 06-20-12 and has bruises multiple locations on her body (R) [right]			

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	face, forehead (R) arm, around the eye to count the major ones. [Resident] is very confused today ... is high fall risk and needs assistance with all ADL's [activities of daily living] transfers/walking." The nurses notes, documented by Licensed Nurse employee #8, and dated 06-22-12 at 4:41 a.m., "Note Test: F/U [follow up] continues for fall. No new injuries noted. Scant amount of blood noted in toilet and brief dx. [diagnosis] hemorrhoids. Vital sign <sic> @ [at] 12 a.m. [blood pressure]137/84, [pulse] 89, [respirations] 18, T [temperature] 98.2, O2 [oxygen saturation level] 94% ra [room air] resident denies pain early at start of shift. At 2:30 a.m. resident c/o [complained of] headache, lethargy, diaphoretic. BP [blood pressure] 98/66, [pulse] 75, [respirations] 16, O2 saturation 94% RA. Resident unable to swallow prn [as needed] Tylenol c/o headache. MD [Medical Doctor] notified, no new order at this time."			

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	Interview on 07-06-12 at 5:15 a.m., Licensed Nurse employee #8 indicated the following; "I came in and got report and was told to watch [resident] because [resident] kept trying to get up. The CNA [certified nurses aide employee #9] called me in. He said [name of resident] was in the bathroom and is bleeding - it was hemorrhoids. There was blood in the toilet. [Name of resident] was sitting on the toilet. The CNA [employee #8] put [resident] back to bed and the vital signs were ok. [Resident] slept. The CNA called after a few hours and said 'I need you in here' and I went to the room. [Resident] was sitting on the side of the bed] and said [resident] had a headache. I checked the vital signs and they were different. The blood pressure was 98 over something, but the O2 and respirations were ok. [Resident] was sweating and temperature was spiking. I got Tylenol and [resident] took 1/2 of it. I waited a little bit and then			

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	called the doctor. I called the office [in regard to the physician's office] and the lady, the nurse, gave me an order for Tylenol suppository. She [the lady nurse] asked me - I told condition and asked if I could send [resident] out. She said since the resident is DNR [Do Not Resuscitate] I cannot give you an order to send [resident] out. She told me to ask the family. I called the Unit Manager [Licensed Nurse employee #3] before the family call. She [the Unit Manager] told me since the resident was a DNR, call and ask the family what they want. She asked me if I called the Doctor and I said 'yes' and I told her the office [lady nurse] wouldn't give me an order to send the resident out since the resident is a DNR. I gave the Tylenol suppository. When I talked to [resident] she tried to respond but couldn't. I waited for family to call. When I talked to [name of Unit Manager] she told me to do as the family and Doctor say and 'there's nothing we can do.' [Name			

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	of resident] didn't have any other bruises other than what was on the face." Interview on 07-06-12 at 5:45 a.m. CNA employee #9 indicated, "The evening shift CNA told me [resident] had fallen and was constantly getting up without supervision and that [resident] was a fall risk. That is when all the craziness started. The call light came on because the roommate needed to go to the bathroom. [Resident "A"] was already on the toilet. There was massive blood and clots in the toilet, almost like when a women has a period [menses]. Every time I changed [resident] there were clots in the brief [incontinent]. They [in reference to the nurses] told me it was just hemorrhoids and they gave me a cream to put on the hemorrhoid. I was in that room a lot for both [resident] and the roommate. The roommate called for assistance to go to the bathroom and when I went in there was a trail			

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	of blood from the bathroom to the bed. [Resident "A"] was half on the bed. There was blood on the sheets and I had to change [resident], the bed and then pulled [resident] up in bed. [Name of Licensed Nurse employee #8] helped me. Then later [name of CNA employee#10] came down to help me with call lights. She went to help [name of Resident "A"] roommate - that's when I could see that [Resident "A"] was not normal. I got [name of Licensed Nurse employee #8] to come down. There was bruising on [resident] face and arms - and didn't look good. [Name of CNA employee #10] sat with [resident] and I went to get [name of Licensed Nurse employee #8] again. [Name of resident] was laying on stomach and shivering." Interview on 07-06-12 at 5:55 a.m. CNA employee #10 indicated, I was working on TCU [Transitional Care Unit]. I walked down here [in reference to the area where CNA employee #9] was working. She			

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	[CNA employee #9] was taking care of [name of resident "A"]. I had [Resident "A"] 2 days earlier and when I walked in [name of Resident "A"] was naked and lying face down on the bed. [Resident "A"] was dry heaving and there was a lot of saliva under [resident]. [Resident "A"] was burning up. [Resident "A"] was shaking like having a seizure. I told [name of Licensed Nurse employee #8] to check [resident] out. [Resident] told me 'something's wrong, my head hurts, something's wrong.' [Resident] was drooling mucousy saliva. I told [name of Licensed Nurse employee #8] that if [resident] says something's wrong, then something is wrong [emphatic]. The first night I had [Resident "A"] had a fall. [Resident] didn't know where [resident] was at, confused and anxious. The complete side of the face was purple black and blue. It looked like someone beat [resident] up."			

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	The record indicated the resident was transported to the local area hospital at approximately 7:15 a.m. on 06-22-12, over 4 hours after the resident displayed signs and symptoms of a change in condition and lacked any additional assessments of the resident's condition or decline since the original noted decline in condition at 2:30 a.m. The local area hospital Emergency room record, reviewed on 07-03-12 at 2:00 p.m., indicated the resident had "intracranial hemorrhage, subdural hemorrhage and altered mental status with increase respiratory rate and fever, pupils pinpoint and non reactive [to light], with extensive bruising noted to the right side of head." The hospital CT scan of the resident's head without contrast, dated 06-22-12, indicated "There is a large acute right subdural hemorrhage present measuring 3 cm [centimeters] in greatest			

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	thickness. Approximately 16 mm [millimeters] of right to left midline shift of the lateral ventricles is noted as described above. There is entrapment of left lateral ventricle. Significant impression and slight rotation of the brainstem due to mass affect is observed. Within the hemorrhage is noted which may reflect areas of unclotted blood. The hemorrhage extends into the right temporal lobe region and along the anterior inferior aspect of the right anterior cranial fossa. In the inferior temporal lobe region, the hemorrhage measures approximately 2 cm [centimeters] in thickness. Dilation of the left lateral ventricle is noted consistent with entrapment." The hospital Discharge Summary, dated 06-23-12 indicated the resident was "admitted from nursing home after a fall and acute loss of consciousness and found to have a large subdural hematoma at admission." The record further indicated the resident was then			

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	admitted to the hospital Hospice, where on 06-24-12 at 2250 [10:50 p.m.] the resident expired. The Medication Administration Record [June 2012] indicated the resident received the Lovenox on 06-20-12, and the Plavix on 06-20-12 and again on 06-21-12. Review of "The Nursing Spectrum Drug Handbook," on 07-12-12 at 2:30 p.m., indicated Lovenox was an anticoagulant with "precautions" which included "adverse reactions of headache, confusion, dizziness, nausea, vomiting, bleeding tendency, hemorrhage, and bruising. The section of the handbook related to "monitoring" included "watch for signs and symptoms of bleeding or bruising, and was "contraindicated in active major bleeding." The medication Plavix also inhibited platelet aggregation and "adverse reactions" included dizziness, headache, and GI [gastrointestinal] bleeding."			

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	"Patient Monitoring" included to monitor the patient for unusual bleeding or bruising as the drug significantly increases risk of bleeding. Further interview on 07-06-12 at 6:15 a.m., Licensed Nurse employee #8 indicated she would continue to follow the same set of instructions when a resident was identified as a DNR - "call the Doctor first, the Unit Manager and follow the orders. We only send a resident out to the hospital as 911 if they are a full code." The facility "Clinical Services FYI [for your information] - Post Fall Evaluation, dated March 2011, provided by the Interim Director of Nurses, indicated the following" "Falls are a common source of patient injury. A comprehensive clinical evaluation by the nurse supervisor is important to determine the extent of injury and the need for additional intervention.			

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	Do not move the patient prior to completing the evaluation. Mental status - patients with suspected head or neck injury should not be moved until evaluated by emergency personnel. Motor function - acute head and neck injuries require additional evaluation. Skin integrity, laceration, abrasion, bruises - Patients with significant injuries may require transfer to an acute care facility for evaluation and treatment. Changes in communication when compared to baseline may be indicative of impending stroke, cardiovascular compromise or other neurological involvement. Medication - Anticoagulant therapy combined with a head injury increases the risk for intracranial bleeding. In the event of a fall with suspected head, neck or spinal injury, staff should keep the patient warm but not move the patient until emergency personnel arrive or head, neck or spinal injury has been ruled out. The licensed nurse's evaluation of a			

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	patient's condition after a fall, identification of changes in condition and recognition of emergent situations is critical to achieving positive patient outcomes. The licensed nurse is responsible for completing this evaluation and reporting changes in condition to the attending physician whenever any symptom, sign or apparent discomfort is sudden in onset, a marked change in relation to usual symptoms or unrelieved by initial interventions." Review of the Encyclopedia and Dictionary of Medicine, Nursing and Allied Health - Second edition on 07-09-12 at 3:00 p.m., indicated the following related to the need for monitoring of a resident who sustained a head injury as the result of a fall. "Continuous monitoring of the vital signs and assessment of the neurological status are essential to the care of the resident with a head injury. Any one of the following			

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	symptoms should be reported to the physician (1) changes in the blood pressure, pulse or respiratory rate, especially slowing of the pulse with a rising blood pressure, (2) extreme restlessness or excitability following a period of comparative calm. (3) deepening stupor of intensity, (5) vomiting, especially persistent, projectile vomiting (6) unequal size of pupils, (7) inability to move one or more extremity." This Federal deficiency relates to Complaint IN00110794. 3.1-37(a)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	8549 S MADISON AVE INDIANAPOLIS, IN 46227

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F0323 SS=G	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 observation, interview and record review the facility failed to ensure supervision and assistive devices for residents, in that when residents had a history of falls, the facility failed to provide assistive devices to protect the resident from injury in the event of a fall. This deficient practice resulted where resident ["A"] sustained a head injury with extensive bruising and continued to displayed a decline in condition which included massive bleeding, complaints of a headache, inability to verbalize and nausea/vomiting and eventual death. This effected 1 of 1 resident's identified with dementia/confusion and a history of falls at the time of admission, and 1 of 1 residents	F0323	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?** Residents A and D have been discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Current residents will receive a fall assessment to be completed by nursing management. Residents determined to be a fall-risk will have fall interventions reviewed and changes implemented as needed. New admissions will have a fall assessment and	08/07/2012

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	reviewed for a history of falls and the potential of fall with injury in a sample of 5. [Residents "A" and "D"]. Findings include: 1. The record for Resident "A" was reviewed on 07-03-12 at 10:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, depressive disorder, scoliosis, hypertension and a history of urinary tract infections. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 06-19-12 after a brief hospitalization for a urinary tract infection and sepsis. The hospital discharge summary, dated 06-19-12 indicated the resident had acute delirium, cardiomegaly and was identified as a fall risk. The hospital fall scale, dated 06-19-12, prior to admission to the facility indicated "confusion,		interventions implemented as necessary upon admission. The Director of Care Delivery/designee updates the Resident Kardex used by direct care staff with new/changes in fall interventions and completes a bedside validation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed nursing staff have been in-serviced on post fall evaluation and implementation of fall interventions. In addition, the continued use of anticoagulants in patient that have had a fall. The Director of Care Delivery/designee updates the Resident Kardex used by direct	

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	provide regular reality orientation, give directions one step at a time to allow time for comprehension, purposeful rounding every 30 minutes and document check, DO NOT leave resident unattended in bathroom or on bedside commode, attempt room placement close to nursing station, use bed check alarms and chair alarm." The preadmission Physician Certification for Long Term Care Services, 450B assessment, dated and signed by the physician on 06-19-12 indicated the resident was "confused/disoriented, and high fall risk due to confusion and unsteady gait." The admission physician orders dated 06-19-12 included Plavix [a platelet inhibitor] 75 mg daily and Lovenox 30 mg [milligrams] per 0.3 ml [milliliters] sq [subcutaneous] q [every] HS [bedtime]. The Physical Therapy Evaluation		care staff with new/changes in fall interventions and completes a bedside validation. **How will the corrective actions be monitored to ensure they do not occur again?** A QAA monitoring tool will be completed by ADNS/Designee on post fall evaluation, intervention implementation and Physician notification of anticoagulant usage in patients with current fall. 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 monthly. **By what date will the changes occur?** 8/7/2012	

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	dated 06-20-12 indicated the resident was "oriented to person and at high risk for falls, presents with decreased strength, decreased balance, difficulty with bed mobility, transfer and ambulation high risk for fall." The Occupational Therapy Evaluation, dated 06-20-12 indicated the resident had "decreased independence with self care, decreased safety, decreased cognition high risk for falls." The resident record indicated the following incidents. "06-20-12 at 8:11 a.m. Found resident laying supine position on bedside mat. Dx. [diagnoses] Alzheimer's, unable to follow direction to use call light even though given frequent reminders and cueing since admission. Resident may have been attempting to get to toilet <sic>. No injury found. Neuro checks WNL [within normal limits]."			

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	"06-20-12 11:30 p.m. Writer went to check on resident and found resident sitting at the edge of the bed with a raised area on the upper right eye, slightly purple in color. Area measuring 9 cm [centimeters] by 7 cm. Resident states ... fell early, when going to kitchen to get a drink and hit his <sic> head on floor ... " "Ice pack was applied to the raised area on the upper right eye, helpful." The Rehabilitation progress notes, dated 06-21-12 indicated the resident was "seen today for skilled physical therapy. Pt had a fall on 06-20-12 and has bruises multiple locations on body (R) [right] face, forehead (R) arm, around the eye to count the major ones ... is very confused today ... is high fall risk and needs assistance with all ADL's [activities of daily living] transfers/walking." During the daily exit conference on 07-03-12 at 12:45 p.m., the			

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	Administrator indicated that once the resident fell, the room was changed to be closer to the nurses station. Interview on 07-05-12 at 10:05 a.m. the Unit Manager Licensed Nurse employee #3 indicated if a resident fell and there is an injury, a body assessment is suppose to be done, once the area was found, a head to toe assessment is completed. Interview on 07-05-12 at 10:35 a.m. CNA employee #5 indicated [name of Resident "A"] would get up by self a lot [emphatic]. Interview on 07-06-12 at 10:30 a.m. the Interim Director of Nurses verified a completed body assessment was not conducted on Resident "A" after the falls. The nurses notes, documented by Licensed Nurse employee #8, and dated 06-22-12 at 4:41 a.m., "Note Test: F/U [follow up] continues for			

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	fall. No new injuries noted. Scant amount of blood noted in toilet and brief dx. [diagnosis] hemorrhoids. Vital sign <sic> @ [at] 12 a.m. [blood pressure]137/84, [pulse] 89, [respirations] 18, T [temperature] 98.2, O2 [oxygen saturation level] 94% ra [room air] resident denies pain early at start of shift. At 2:30 a.m. resident c/o [complained of] headache, lethargy, diaphoretic. BP [blood pressure] 98/66, [pulse] 75, [respirations] 16, O2 saturation 94% RA. Resident unable to swallow prn [as needed] Tylenol c/o headache. MD [Medical Doctor] notified, no new order at this time." Interview on 07-06-12 at 5:15 a.m., Licensed Nurse employee #8 indicated the following; "I came in and got report and was told to watch [resident] because [resident] kept trying to get up. The CNA [certified nurses aide employee #9] called me in. He said [name of resident] was in the bathroom and is bleeding - it was			

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	hemorrhoids. There was blood in the toilet. [Name of resident] was sitting on the toilet. The CNA [employee #8] put [resident] back to bed and the vital signs were ok. [Resident] slept. The CNA called after a few hours and said 'I need you in here' and I went to the room. [Resident] was sitting on the side of the bed] and said [resident] had a headache. I checked the vital signs and they were different. The blood pressure was 98 over something, but the O2 and respirations were ok. [Resident] was sweating and temperature was spiking. I got Tylenol and [resident] took 1/2 of it. I waited a little bit and then called the doctor. I called the office [in regard to the physician's office] and the lady, the nurse, gave me an order for Tylenol suppository. She [the lady nurse] asked me - I told condition and asked if I could send [resident] out. She said since the resident is DNR [Do Not Resuscitate] I cannot give you an order to send [resident] out. She told me to ask the family. I			

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	called the Unit Manager [Licensed Nurse employee #3] before the family call. She [the Unit Manager] told me since the resident was a DNR call and ask the family what they want. She asked me if I called the Doctor and I said 'yes' and I told her the office [lady nurse] wouldn't give me an order to send the resident out since the resident is a DNR. I gave the Tylenol suppository. When I talked to [resident] she tried to respond but couldn't. I waited for family to call. When I talked to [name of Unit Manager] she told me to do as the family and Doctor say and 'there's nothing we can do.' [Name of resident] didn't have any other bruises other than what was on the face." Interview on 07-06-12 at 5:45 a.m. CNA employee #9 indicated, "The evening shift CNA told me [resident] had fallen and was constantly getting up without supervision and that [resident] was a fall risk. That is when all the			

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	craziness started. The call light came on because the roommate needed to go to the bathroom. [Resident "A"] was already on the toilet. There was massive blood and clots in the toilet, almost like when a women has a period [menses]. They [in reference to the nurses] told me it was just hemorrhoids and they gave me a cream to put on the hemorrhoid. Every time I changed [resident] there were clots in the brief [incontinent]. I was in that room a lot for both [resident] and the roommate. The roommate called for assistance to go to the bathroom and when I went in there was a trail of blood from the bathroom to the bed. [Resident "A"] was half on the bed. There was blood on the sheets and I had to change [resident], the bed and then pulled [resident] up in bed. [Name of Licensed Nurse employee #8 helped me. Then later [name of CNA employee#10] came down to help me with call lights. She went to help [name of Resident "A"]			

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	roommate - that's when I could see that [Resident "A"] was not normal. I got [name of Licensed Nurse employee #8] to come down. There was bruising on [resident] face and arms - and didn't look good. [Name of CNA employee #10] sat with [resident] and I went to get [name of Licensed Nurse employee #8] again. [Name of resident] was laying on stomach and shivering." Interview on 07-06-12 at 5:55 a.m. CNA employee #10 indicated, I was working on TCU [transitional care unit]. I walked down here [in reference to the area where CNA employee #9] was working. She [CNA employee #9] was taking care of [name of resident "A"]. I had [Resident "A"] 2 days earlier and when I walked in [name of Resident "A"] was naked and lying face down on the bed. [Resident "A"] was dry heaving and there was a lot of saliva under [resident]. [Resident "A"] was burning up. [Resident "A"] was shaking like having a seizure. I told [name of			

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	Licensed Nurse employee #8] to check [resident] out. [Resident] told me 'something's wrong, my head hurts, something's wrong.' [Resident] was drooling mucousy saliva. I told [name of Licensed Nurse employee #8] that if [resident] says something's wrong, then something is wrong [emphatic]. The first night I had [Resident "A"] had a fall. I went and got a mat and put the bed down in the low position. [Resident] didn't know where [resident] was at, confused and anxious. The complete side of the face was purple black and blue. It looked like someone beat [resident] up." The record lacked documentation of a fall on the evening shift of 06-21-12. The resident was transported to the local area hospital at approximately 7:15 a.m. on 06-22-12, over 4 hours after the resident displayed signs and symptoms of a change in condition at 2:30 a.m.			

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	The local area hospital Emergency room record, reviewed on 07-03-12 at 2:00 p.m., indicated the resident had "intracranial hemorrhage, subdural hemorrhage and altered mental status with increase respiratory rate and fever, pupils pinpoint and non reactive [to light], with extensive bruising noted to the right side of head." The hospital CT scan of the resident's head without contrast, dated 06-22-12, indicated "There is a large acute right subdural hemorrhage present measuring 3 cm [centimeters] in greatest thickness. Approximately 16 mm [millimeters] of right to left midline shift of the lateral ventricles is noted as described above. There is entrapment of left lateral ventricle. Significant impression and slight rotation of the brainstem due to mass affect is observed. Within the hemorrhage is noted which may reflect areas of unclotted blood. The hemorrhage extends into the right temporal lobe region and			

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	along the anterior inferior aspect of the right anterior cranial fossa. In the inferior temporal lobe region, the hemorrhage measures approximately 2 cm [centimeters] in thickness. Dilation of the left lateral ventricle is noted consistent with entrapment." The hospital Discharge Summary, dated 06-23-12 indicated the resident was "admitted from nursing home after a fall and acute loss of consciousness and found to have a large subdural hematoma at admission." The record further indicated the resident was then admitted to the hospital Hospice, where on 06-24-12 at 2250 [10:50 p.m.] the resident expired. The Medication Administration Record [June 2012] indicated the resident continued to receive the Lovenox on 06-20-12, and the Plavix on 06-20-12 and again on 06-21-12. Review of "The Nursing Spectrum			

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	Drug Handbook," on 07-12-12 at 2:30 p.m., indicated Lovenox was an anticoagulant with "precautions" which included "adverse reactions of headache, confusion, dizziness, nausea, vomiting, bleeding tendency, hemorrhage, and bruising. The section of the handbook related to "monitoring" included "watch for signs and symptoms of bleeding or bruising, and was "contraindicated in active major bleeding." The medication Plavix also inhibited platelet aggregation and "adverse reactions" included dizziness, headache, and GI [gastrointestinal] bleeding." "Patient Monitoring" included to monitor the patient for unusual bleeding or bruising as the drug significantly increases risk of bleeding. 2. The record for Resident "D" was reviewed on 07-06-12 at 10:35 a.m. Diagnoses included but were not limited to, breast cancer, gastritis, nausea and vomiting, abdominal			

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	pain, spinal stenosis and dehydration. These diagnoses remained current at the time of the record review. The local area hospital transfer papers, dated 07-04-12 indicated the resident was a "fall risk." Interview on 07-06-12 at 10:20 a.m. Licensed Nurse employee #13 indicated the resident had recently been admitted to the facility and had a history of falls. "[Resident] is sleeping right now. I had to give Phenergan for the nausea and vomiting. Yesterday was a good day, today not so much. I was told [resident] was a fall risk when admitted - I was told in report. No the bed isn't in a low position or is there a mat next to the bed." Observation on 07-06-12 at 11:30 a.m., the resident was observed seated upright in bed. The bed was in a high position and there was no mat on the floor adjacent to the bed.			

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	4. During the Initial Tour of the facility on 07-03-12 at 9:15 a.m., with the Interim Director of Nurses and Unit Manager in attendance, the Unit Manager indicated if a resident is admitted to the facility and is known fall risk "we immediately place the bed in a low position and place a mat next to the bed." This Federal deficiency relates to Complaint IN00110794. 3.1-45(a)(2)			

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F0329 SS=G	483.25(l) 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. 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.			
	Based on observation, record review and interview, the facility failed to ensure residents were free from unnecessary medications, in that when resident had falls and sustained head injuries, the nursing staff continued to administer anticoagulation therapy. The residents sustained bruising to the face and temple area. The nursing staff continued to dispense	F0329	It is the practice of Manor Care Indy South to provide a drug regimen free from unnecessary medications for all residents. **What corrective action will be accomplished for those residents who have been affected by the deficient practice?** Resident # A has been discharged from the facility. We contacted the physician for resident # C and no changes were ordered for anticoagulants. **How other residents having the potential to be affected by the**	08/07/2012

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	anticoagulation therapy to the residents which inhibited platelet formation for to 2 of 3 resident's reviewed for falls and a head injury, which resulted in the death of 1 resident in a sample of 5. [Resident "A" and "C"]. Findings include: The record for Resident "A" was reviewed on 07-03-12 at 10:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, depressive disorder, scoliosis, hypertension and a history of urinary tract infections. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 06-19-12 after a brief hospitalization for a urinary tract infection and sepsis. The hospital discharge summary, dated 06-19-12 indicated the resident had acute delirium, cardiomegaly and was identified as		**same deficient practice will be identified and what corrective action will be taken?** Residents with ordered anticoagulants were reviewed for fall risk and their current fall interventions were reviewed with changes implemented as needed. The physician will be notified of any falls by residents who receive anticoagulants and anticoagulant orders will be changed as physician deems necessary. The Nurse Supervisors completes a post fall evaluation on residents that have fallen. The Nurse Supervisor uses the Post Fall Evaluation Worksheet that has a category titled Medication and Anticoagulant which is listed to trigger a medication review. The	

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	a fall risk. The hospital fall scale, dated 06-19-12, prior to admission to the facility indicated "confusion, provide regular reality orientation, give directions one step at a time to allow time for comprehension, purposeful rounding every 30 minutes and document check, DO NOT leave resident unattended in bathroom or on bedside commode, attempt room placement close to nursing station, use bed check alarms and chair alarm." The preadmission Physician Certification for Long Term Care Services, 450B assessment, dated and signed by the physician on 06-19-12 indicated the resident was "confused/disoriented, and high fall risk due to confusion and unsteady gait." The admission physician orders dated 06-19-12 included Plavix [a platelet inhibitor] 75 mg daily and Lovenox 30 mg [milligrams] per 0.3 ml [milliliters] sq [subcutaneous] q [every] HS		Nurse Supervisor will discuss the medication review with the physician to make decisions regarding medications that impact the resident post fall. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed nursing staff have been in-serviced on: Ø Post Fall Evaluation, including emphasis on the use of anticoagulants and risk with head injury; notification of Physician for clarification of continued use after a fall. **How will corrective actions be monitored to ensure that they do not reoccur?** QAA monitoring tool will be completed by ADNS/Designee on patient injury or post fall evaluation and anticoagulant usage in patients with falls. 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 monthly. **By what date will the changes**	

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	[bedtime]. The resident record indicated the following incidents. "06-20-12 at 8:11 a.m. Found resident laying supine position on bedside mat. Dx. [diagnoses] Alzheimer's, unable to follow direction to use call light even though given frequent reminders and cueing since admission. Resident may have been attempting to get to toilet <sic>. No injury found. Neuro checks WNL [within normal limits]." The nurses started the neurological evaluation flow sheet on 06-20-12 at 5:30 a.m. The directions at the top of this form instructed the nursing staff to "complete neurological evaluation with vital signs initially, then every 30 minutes times 4, then every hour times, 4, then every 8 hours times 9 (72 hours). More frequent evaluations may be necessary. Use both sides of this form and		**occur?** 8/7/2012	

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	additional forms if necessary. Complete episodic charting for at least 72 hours including any pertinent evaluation findings related to the neurological evaluation. Review the most recent evaluation on the medical record and notify the Physician of any changes from previous evaluation." "06-20-12 11:30 p.m. Writer went to check on resident and found resident sitting at the edge of the bed with a raised area on the upper right eye, slightly purple in color. Area measuring 9 cm [centimeters] by 7 cm. Resident states fell early, when going to kitchen to get a drink and hit his <sic> head on floor ... " "Ice pack was applied to the raised area on the upper right eye, helpful." The Licensed Nurses continued the neurological checks as directed including when the resident was found with the raised area to the right side of the head. During interview on 07-05-12 at 10:30 a.m.			

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	the Unit Manager Licensed Nurse employee #3 indicated the nursing staff "should have started the neuro checks over once they discovered the bump." The nurses notes, documented by Licensed Nurse employee #8, and dated 06-22-12 at 4:41 a.m., "Note Test: F/U [follow up] continues for fall. No new injuries noted. Scant amount of blood noted in toilet and brief dx. [diagnosis] hemorrhoids. Vital sign <sic> @ [at] 12 a.m. [blood pressure]137/84, [pulse] 89, [respirations] 18, T [temperature] 98.2, O2 [oxygen saturation level] 94% ra [room air] resident denies pain early at start of shift. At 2:30 a.m. resident c/o [complained of] headache, lethargy, diaphoretic. BP [blood pressure] 98/66, [pulse] 75, [respirations] 16, O2 saturation 94% RA. Resident unable to swallow prn [as needed] Tylenol c/o headache. MD [Medical Doctor] notified, no new order at this time."			

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	Interview on 07-06-12 at 5:15 a.m., Licensed Nurse employee #8 indicated the following; "I came in and got report and was told to watch [resident] because [resident] kept trying to get up. The CNA [certified nurses aide employee #9] called me in. He said [name of resident] was in the bathroom and is bleeding - it was hemorrhoids. There was blood in the toilet. [Name of resident] was sitting on the toilet. The CNA [employee #8] put [resident] back to bed and the vital signs were ok." Interview on 07-06-12 at 5:45 a.m. CNA employee #9 indicated, "The evening shift CNA told me [resident] had fallen and was constantly getting up without supervision and that [resident] was a fall risk. That is when all the craziness started. The call light came on because the roommate needed to go to the bathroom. [Resident "A"] was already on the toilet. There was massive blood and clots in the toilet, almost like			

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	when a women has a period [menses]. Every time I changed [resident] there were clots in the brief [incontinent]. They [in reference to the nurses] told me it was just hemorrhoids and they gave me a cream to put on the hemorrhoid. I was in that room a lot for both [resident] and the roommate. The roommate called for assistance to go to the bathroom and when I went in there was a trail of blood from the bathroom to the bed. [Resident "A"] was half on the bed. There was blood on the sheets and I had to change [resident], the bed and then pulled [resident] up in bed." Interview on 07-06-12 at 5:55 a.m. CNA employee #10 indicated, I was working on TCU [transitional care unit]. I walked down here [in reference to the area where CNA employee #9] was working. She [CNA employee #9] was taking care of [name of resident "A"]. I had [Resident "A"] 2 days earlier and when I walked in [name of			

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	Resident "A"] was naked and lying face down on the bed. The complete side of the face was purple black and blue. It looked like someone beat [resident] up." The record indicated the resident was transported to the local area hospital at approximately 7:15 a.m. on 06-22-12, over 4 hours after the resident displayed signs and symptoms of a change in condition at 2:30 a.m. The local area hospital Emergency room record, reviewed on 07-03-12 at 2:00 p.m., indicated the resident had "intracranial hemorrhage, subdural hemorrhage and altered mental status with increase respiratory rate and fever, pupils pinpoint and non reactive [to light], with extensive bruising noted to the right side of head." The hospital CT scan of the resident's head without contrast, dated 06-22-12, indicated "There is a large acute right subdural			

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	hemorrhage present measuring 3 cm [centimeters] in greatest thickness. Approximately 16 mm [millimeters] of right to left midline shift of the lateral ventricles is noted as described above. There is entrapment of left lateral ventricle. Significant impression and slight rotation of the brainstem due to mass affect is observed. Within the hemorrhage is noted which may reflect areas of unclotted blood. The hemorrhage extends into the right temporal lobe region and along the anterior inferior aspect of the right anterior cranial fossa. In the inferior temporal lobe region, the hemorrhage measures approximately 2 cm [centimeters] in thickness. Dilation of the left lateral ventricle is noted consistent with entrapment." The hospital Discharge Summary, dated 06-23-12 indicated the resident was "admitted from nursing home after a fall and acute loss of consciousness and found to have a large subdural hematoma at			

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	admission." The Medication Administration Record [June 2012] indicated the resident received the Lovenox on 06-20-12, and the Plavix on 06-20-12 and again on 06-21-12. Review of "The Nursing Spectrum Drug Handbook," on 07-12-12 at 2:30 p.m., indicated Lovenox was an anticoagulant with "precautions" which included "adverse reactions of headache, confusion, dizziness, nausea, vomiting, bleeding tendency, hemorrhage, and bruising. The section of the handbook related to "monitoring" included "watch for signs and symptoms of bleeding or bruising, and was "contraindicated in active major bleeding." The medication Plavix also inhibited platelet aggregation and "adverse reactions" included dizziness, headache, and GI [gastrointestinal] bleeding." "Patient Monitoring" included to monitor the patient for unusual			

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	bleeding or bruising as the drug significantly increases risk of bleeding. 2. The record for Resident "C" was reviewed on 07-05-12 at 1:00 p.m. Diagnoses included but were not limited to coronary artery disease, hypertension, congestive heart failure, pain and clostridium difficile. These diagnoses remained current at the time of the record review. The resident had physician orders dated 04-24-12 for Aspirin 81 mg once daily and Plavix 75 mg once daily. During the initial tour of the facility on 07-03-12 at 9:30 a.m., the Unit Manager Licensed Nurse employee #3 indicated the resident had fallen, hit head and had an injury related to the fall. The nurses notes indicated the resident fell on 06-28-12 at 12:15 p.m. "Called to resident's room per			

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	CNA [certified nurses aide], resident found on floor lying on left side with left side of head against base of table. Alert and responsive. Small amount of blood noted on floor, next to residents head. Laceration measuring .5 cm [centimeters] in length noted above left eye, small amount of active bleeding. Two steri-strips applied to approximate wound edges. Ace applied to forehead, bleeding subsided." The facility Incident Report, dated 06-28-12 at 10:30 a.m. indicated the resident was "found lying on floor, left side of head on base of table. small amount of blood noted on floor." Observation on 07-05-12 at 11:00 a.m., Resident "C" was observed seated in the wheelchair. The resident indicated a fall occurred "a few days ago" but didn't know what had happened. The resident pulled the hair from the forehead a large bruised area was noted above the			

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	left eye, hair line and temple area. The Nurses notes dated 07-05-12 at 05:05 a.m. indicated the resident "con't [continued] to have multi-bruising area and to left upper eye ... ." Review of the Medication Administration record for June 2012 indicated the resident continued to receive the Plavix and Aspirin therapy since the time of the fall. Review of "The Nursing Spectrum Drug Handbook," on 07-12-12 at 2:30 p.m., indicated the medication Plavix inhibited platelet aggregation and "adverse reactions" included dizziness, headache, and GI [gastrointestinal] bleeding." "Patient Monitoring" included to monitor the patient for unusual bleeding or bruising as the drug significantly increases risk of bleeding. The medication Aspirin had and antiplatelet effect and "precautions"			

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	included to "use in extreme in caution in elderly patients, with "adverse reactions" to include GI bleeding, nausea, vomiting and bruising. "Patient Monitoring" indicated to "watch" for adverse reactions, especially bleeding tendency, incoherent speech, confusion, lethargy" and the need to report unusual bleeding and bruising. This Federal deficiency relates to Complaint IN00110794. 3.1-48(a)(5)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview the facility failed to provide medications, in that when a physician ordered medications for a resident, the facility failed to ensure the medication was provided from the pharmacy and administered following the physician order to the resident for 3 of 4 resident's reviewed for medications in a sample of 5. [Residents "A", "B" and "D"].	F0425	It is the practice of Manor Care Indy South to provide all residents with pharmaceutical services to meet their individual needs. Manor Care Indy South does employ a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services within the facility. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Residents A B and D have been discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be**	08/07/2012

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	Findings include: 1. The record for Resident "A" was reviewed on 07-03-12 at 10:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, depressive disorder, scoliosis, hypertension and a history of urinary tract infections. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 06-19-12 after a brief hospitalization for a urinary tract infection and sepsis. At the time the resident was admitted to the facility, physician orders included Vitamin B12 1000 mg [milligrams] daily, Lovenox [an anticoagulant] 30 mg/0.3 ml [milliliters] SQ [subcutaneous] at bedtime, Plavix [an antiplatelet inhibitor medication] 75 mg daily, Aricept [a medication used for Alzheimer's disease] 10 mg at bedtime, Zoloft [an antidepressant] 100 mg daily, Levothyroxine [a		**identified and what corrective action will be taken?** All residents have the potential for a medication to be unavailable. A medication cart audit was completed to make sure all current medications are available. If a medication is not available the DON/designee will be made aware, the pharmacy will be contacted to request an immediate drop shipment. In addition residents that discharge may be affected by this practice. Medication disposition forms will be completed for all discharging residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed nursing staff will be in-serviced on the appropriate response to medications that are unavailable, appropriate documentation of medication administration and disposition; and appropriate procedures for Medication Administration. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** Medication cart and Medication Administration Record (MAR) will be monitored weekly x4 weeks and then monthly times 3 months by ADNS or designee to check for medication availability. The Unit managers or designee will monitor weekly x4 weeks and then	

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	medication to treat hypothyroidism] 25 mcg [micrograms] daily and Atrovastatin [a medication to treat cholesterol] 10 mg at bedtime. The record indicated the Resident was sent to the hospital on 06-22-12 at approximately 7:15 a.m., due to a change in condition. The Medication Administration Record for June 2012 indicated the resident received the Vitamin B12 through 06-21-12, Lovenox on 06-20-12, Plavix through 06-21-12, Aricept through 06-21-12, Zoloft through 06-21-12, Levothyroxine through 06-22-12 and Atrovastatin through 06-21-12. However a review of the pharmacy "receipt for returned products," dated 06-28-12,on 07-05-12 at 10:00 a.m., indicated the following: Levothyroxine - amount received at the facility 30 tablets, amount returned to the pharmacy 27 tablets.		monthly times 3 months the charts of discharging patients to assure documentation of medications disposition. ADNS or designee will complete Medication Pass Observations of Licensed Staff on all shifts x 5 nurses weekly x4 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 monthly. **Date to be completed** 8/7/2012	

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	Plavix - amount received at the facility 30 tablets, amount returned to the pharmacy 29 tablets. Aricept - amount received at the facility 30 tablets, amount returned to the pharmacy 29 tablets. Zoloft - amount received at the facility 30 tablets, amount returned to the pharmacy 29 tablets. Simvastatin - amount received at the facility 30 tablets, amount returned to the pharmacy 29 tablets. During interview on 07-05-12 at 10:30 a.m., the discrepancy was reviewed to the Unit Manager Licensed Nurse employee #3. The Unit Manager verified the discrepancy and further indicated two licensed nurses are required by facility policy to verify the correct count of the medications which are returned to the pharmacy. The Unit Manager questioned the validity of the resident receiving the medications as transcribed on the			

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	Medication Administration Record. 2. The record for Resident "B" was reviewed on 07-03-12 at 11:00 a.m. Diagnoses included but were not limited to chronic obstructive pulmonary disease, atrial fibrillation, depression disorder, hypertension, sepsis, chronic pain syndrome and diabetes mellitus. These diagnoses remained current at the time of the record review. The resident had physician orders for medications which included Fentanyl [a pain medication] 50 mcg [micrograms]/hr [hour] patch apply 1 patch topically every 72 hours, Methadone [an opioid analgesic medication] 10 mg. twice daily. Review of the Medication Administration Record for June 2012 indicated the Fentanyl patch was "unavailable" from the pharmacy on 06-18-12, and the Methadone was "unavailable" from the pharmacy on 06-20-12 at 9:00			

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	a.m., 06-21-12 at 9:00 a.m. and again at 9:00 p.m. In addition, the resident's medications were returned to the pharmacy as "returned products." The pharmacy documentation indicated the medications were returned to the pharmacy on 06-26-12, however the document did not have the required two signatures by the licensed nursing staff of the date the medications were returned. During interview on 07-05-12 at 2:40 p.m., the Unit Manager Licensed Nurse employee #3 verified the omission by the nursing staff and reiterated the facility policy of the required two licensed nurses signatures for verification of returned medications. 3. The record for Resident "D" was reviewed on 07-06-12 at 10:35 a.m. Diagnoses included but were not limited to, breast cancer, gastritis, nausea and vomiting, abdominal			

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	pain, spinal stenos and dehydration. These diagnoses remained current at the time of the record review. At the time the resident was admitted to the facility [07-04-12] the physician orders included levofloxacin [an anti-infective medication] 500 mg [milligrams] every day thru 07-14-12, Duoneb per nebulizer [a respiratory treatment] two times a day, Ambien [a sleeping medication] 5 mg as needed at bedtime, Senna [a laxative] one at bedtime, Collace <sic> [a stool softener] 100 mg two tablets at bedtime and Dexilant [a medication for heartburn] EC [enteric coated] 60 mg everyday. The resident's Medication Administration Record for July 2012 lacked documentation the resident received the prescribed medications as ordered. The resident did not receive 2 doses of the anti-infective medication, 1 respiratory treatment, 2 doses of the laxative and stool softener and 1			

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	dosage of the medication for heartburn relief. In addition the "as needed" sleeping medication was not available to the resident. Interview on 07-06-12 at 1:00 p.m., the Unit Manager Licensed Nurse employee #3 indicated "When you requested the copy of the medication record I noticed the medications had not been given. I asked the nurse what happened and she explained she didn't have time to order the medications for the resident when the resident was admitted to the facility." This Federal deficiency relates to Complaints IN00110794 and IN00111318. 3.1-25(a)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure completed and accurate clinical records for 1 of 5 resident's reviewed. [Resident "A"]. Findings include: The record for Resident "A" was reviewed on 07-03-12 at 10:30 a.m. Diagnoses included but were not limited to Alzheimer's disease, depressive disorder, scoliosis hypertension and a history of urinary tract infections. These diagnoses remained current at the time of the record review.	F0514	It is the policy of Manor Care Indy South to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurate, accessible, and systematically organized. **What corrective action will take place for those residents affected by the deficient practice?** Resident #A has been discharged from facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Residents who transfer to the hospital have the potential to be impacted by having clinical records that do not reflect current medical status. Medical records of current patients who transfer to the hospital will be reviewed to assure accuracy	08/07/2012

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	The resident was admitted to the facility on 06-19-12 after a brief hospitalization for a urinary tract infection and sepsis. The Initial Clinical Assessment, dated 06-19-12 indicated the resident was "cognitive - severely impaired," and "seems to be continent of bowel and bladder." The facility "Bladder Patterning and Analysis Worksheet," instructed the nursing staff to "use the chart to document voiding patterns on 3 days for 3 shifts. Check the resident every 2 hours and PRN [as needed]and document voiding pattern." The "Bladder Patterning and Analysis Worksheet, " indicated the resident was continent on 06-20-12 from 12:00 a.m. thru 11:00 p.m., continent on 06-21-12 from 12:00 a.m. thru 11:00 p.m., and continent on 06-22-12 from 12:00 a.m. thru 5:00 p.m.		of assessment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed Nurses were educated on Documentation Guidelines and the use of the Computerized Transfer Form. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** A QA audit tool will be completed by the ADNS/Designee on documentation on the Computerized Transfer Form for those residents that have been transferred to the hospital and assure that no other documentation occurs in clinical record after transfer. 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 monthly **Date to be completed.** 8/7/2012	

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	The record indicated the resident had a change in condition and was transported to the hospital on 06-22-12 at approximately 7:15 a.m. In addition, when the resident was transported to the local area hospital on 06-22-12 at approximately 7:15 a.m. the nursing staff used the facility computerized transfer form. The form indicated the transfer was "unplanned," "decision to transfer was made by the on call physician," "reason for transfer - fever/infection," "At risk alerts falls - had fall on 02-20-12 resulting in bump and bruise to right forehead/eye," and the "most recent blood pressure of 107/78, pulse 58, respirations 20, temperature 97.8, and oxygen saturation level at 91%." All vital signs indicated the date as the most recent was "06-19-12." The nursing notes indicated the resident's most "recent" vital signs			

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	were taken on 06-22-12 at 2:30 a.m., and included a blood pressure of 98/66, pulse 75, respirations 16, temperature 99.6 and oxygen saturation level at 94%. In addition the nursing notes indicated the resident was lethargic, diaphoretic, and had complaints of a headache and inability to swallow medications. The facility failed to accurately document notification to the hospital of the resident's condition. This Federal tag relates to Complaint IN00110794. 3.1-50(a)(1) 3.1-50(a)(2)			