STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155005		09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	1345 N MADISON AVE ANDERSON, IN 46011

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00181700. Complaint IN00181700 - Substantiated - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey date: September 23 and 24, 2015 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census bed type: SNF: 24 SNF/NF: 111 Total: 135 Census payor type: Medicare: 13 Medicaid: 91 Other: 31 Total: 135 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

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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	QR completed by 11474 on September 28, 2015.			
F 0514 SS=D Bldg. 00	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 documentation in the resident clinical record was complete for 2 of 3 residents reviewed for complete and accurate clinical records. (Resident C and Resident D) Findings include: 1. The clinical record for Resident #C was reviewed on 9/23/14 at 2:00 p.m.	F 0514	This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in	10/23/2015

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	Diagnoses for the resident included, but were not limited to, renal failure, diabetes, diabetic neuropathy, amputation of right toe and gangrene of the right toe. Review of the clinical record on 9/23/14 at 2:33 p.m., indicated Resident C had an order for dialysis every Monday, Wednesday and Friday. The order was dated 9/12/15. Resident C received 5 (five) dialysis treatments from 9/12/15 through 9/24/15. The clinical record indicated only 1 (one) "Hemodialysis Communication Form" dated 9/18/15. Review of the Medication Administration Record (MAR) on 9/23/14 at 2:33 p.m., indicated Resident C had an order to check the bruit and thrill of the dialysis shunt every shift. On the following dates and times no documentation of the assessment was noted: 9/16/15 6:00 a.m. to 2 p.m., 9/17/15 6:00 a.m. to 2:00 p.m., 9/18/15 6:00 a.m. to 2:100 p.m., 9/18/15 2:00 p.m. to 10:00 p.m., 9/18/15 10:00 p.m. to 6:00 a.m., 9/19/15 6:00 a.m. to 2:00 p.m., 9/19/15 10:00 p.m. to 6:00 a.m., 9/20/15 6:00 a.m. to 2:00 p.m. 9/20/15 10:00 p.m. to 6:00 a.m., 9/21/15 6:00 a.m. to 2:00 p.m., 9/22/15 6:00 a.m. to 2:00 p.m. and 9/22/15 2:00 p.m. to 10:00 p.m. for a total to 12 (twelve) undocumented assessments.		the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. **Tag F514 Records complete/accurate/accessible** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C: Medical record was reviewed and reflects accurate documentation/communication pre and post dialysis treatment and assessment of dialysis site per physician orders. Resident D: Medical record was reviewed and reflects accurate documentation on the Medication Administration Record (MAR) and Treatment Administration Record (TAR)of medications and treatments administered per physician orders per the facility guidelines and any omissions were communicated to the physician and the patient was assessed and records updated to reflect current status. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** Residents that receive dialysis treatment, medications and treatments have the potential to be affected by the same alleged deficient practice. The medical record for residents	

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	Review of the MAR, on 9/23/14 at 2:33 p.m., indicated Resident C had an order for daily skin assessments on the 6:00 a.m. to 2:00 p.m. shift. The MAR lacked any skin assessment from 9/16/15 through 9/23/15. Review of a care plan, dated 9/14/15, titled "Renal Insufficiencies related to: presence of fistula/graft/catheter, end stage renal disease, diabetes" indicated interventions including, but not limited to, "coordinate dialysis care with dialysis treatment center." During an interview on 9/23/15 at 9:21 a.m., the Director of Nursing Services (DON) indicated the following: "The communication form should have been completed by nursing prior to the resident leaving the facility for dialysis." During an interview on 9/24/15 at 1:56 p.m., RN #7 indicated dialysis fistulas were to be checked every shift. "You need to check the fistula, you have to do that every shift. They (dialysis residents) have a book, assess the patient before they leave and send the medication list, blood sugars if they have them, send a meal with them and all their paperwork. If there is anything wonky going on I would call the dialysis center to give them a heads up. They (the dialysis		receiving dialysis therapy have been reviewed including the dialysis communication forms and validated to ensure any follow up was completed and physician updated with any concerns. The medical record for residents that receive medications and treatments have been reviewed and updated to reflect, going forward, accurate documentation of medications and treatments per the physician's orders. **What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;** Licensed Nursing staff have been re-educated on the Dialysis Communication guidelines. Licensed Nursing staff have been re-educated on the Assessment of Arterio Venous Shunts, Fistulas & Grafts guidelines. Licensed Nursing staff have been re-educated on the Medication Administration guidelines. The ADNS or designee will conduct an audit 3 times per week of residents that receive dialysis treatments to ensure the communication form is completed per the facility guidelines. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above. The ADNS or designee will conduct an audit 3 times per week of residents that	

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	center) should send the book back with their information. This should happen every time the residents go to dialysis." During an interview on 9/24/15 at 2:23 p.m., LPN #9 indicated the following: "Dialysis residents have a book and the book should be sent with them to each dialysis appointment. The communication form should be filled out before they leave and sent with the book. The dialysis center is suppose to send the book with their assessment on the form." During an interview on 9/24/15 at 2:32 p.m., RN #8 indicated the following: "We have a communication form we fill out before we send the resident to dialysis. If we have any questions we can call the dialysis center once the resident returns." 2. The clinical record for Resident #D was reviewed on 9/24/14 at 8:14 a.m. Diagnoses for the resident included, but were not limited to, posterior laminectomy and fusion C2-C3, bilateral occipital neuralgia, hypertension and fibromyalgia. Review of the September, 2015 Medication Administration Record (MAR)indicated Resident D had an order for weekly skin assessments on the day		receive dialysis treatment to ensure there is documentation of assessment of the AV Shunt/Fistula site per physician orders. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above. The ADNS or designee will conduct audits 10 times per week of residents that receive medications and treatments to ensure there is accurate documentation on the MAR of completion per physician orders. Findings will be recorded on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;** Audit findings will be presented to the QAA Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process. **By what date the systemic changes will be completed?** **October 23, 2015**	

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	shift. The MAR lacked any skin assessment for 9/22/15. Review of the September, 2015 MAR indicated Resident D had an order, dated 9/16/15, for daily blood pressures and heart rates to be taken on the 6:00 a.m. to 2:00 p.m. shift. The MAR lacked any documentation of the blood pressure or heart rate for the following dates: 9/18/15 and 9/22/15. Review of the September, 2015 MAR indicated Resident D had an order, dated 9/16/15, for Levothyroxine (thyroid hormone replacement medication) 50 mcg (micrograms) every morning before breakfast. The MAR lacked any documentation for the medication on 9/18/15. Review of the September, 2015 MAR indicated Resident D had an order, dated 9/16/15, for Metoprolol Succinate (antihypertensive medication) 50 mg (milligrams) twice daily. The MAR lacked any documentation of the medication on 9/19/15 at 8:00 p.m. Review of the September, 2015 MAR indicated Resident D had an order, dated 9/16/15, for Zoloft (antidepressant medication) 50 mg at bedtime. The MAR lacked any documentation of the			

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	medication on 9/17/15 at 8:00 p.m. Review of the September, 2015 MAR indicated Resident D had an order, dated 9/16/15, for Vitamin B-12 (supplement) 1000 mcg every other day. The MAR lacked any documentation of the medication on 9/18/15 and 9/22/15. During an interview on 9/23/15 at 9:21 a.m., the Director of Nursing Services (DON) indicated medications and treatments should have been documented on the MAR and TAR (Treatment Administration Record) when the medication was administered or when the treatment was completed. Review of a current policy, dated 12/2009, titled "Assessment of Arterio Venous Shunts, Fistulas & Grafts", provided by the DON on 9/24/15 at 11:14 a.m., indicated the following: "...Document completion of assessment on TAR...." Review of a current policy, dated 11/2013, titled "Documentation", provided by the DON on 9/24/15 at 11:14 a.m., indicated the following: "Documentation Purpose: To provide general guidelines regarding the documentation of care provided by nursing personnel...			

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	Hemodialysis Communication Form: Communication between center and dialysis center re: patient status, new orders, medications, labs...." Review of a current policy, dated 3/2010, titled "Medication Administration: Medication Pass", provided by the DON on 9/24/15 at 11:14 a.m., indicated the following: "Medication Administration: Medication Pass...9. Administer medication ...document initials on MAR for each medication administered. 10. Patient Refusal...circle initials on MAR and document refusal on back side of MAR ... Suggested Documentation:...Patient refusals of medication and reason, contact physician for guidance, as necessary." 3.1-50(a)(1)			