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		08/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN001798701, IN00179216 and IN00179263. Complaint IN00178701 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F279, F309. Complaint IN00179216 - Unsubstantiated due to lack of evidence. Complaint IN00179263 - Substantiated. Federal/State deficiencies related to the allegations are cited at F456 . Survey date: August 4 and 5, 2015 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census bed type: SNF: 14 SNF/NF: 127 Total: 141 Census payor type: Medicare: 14 Medicaid: 97 Other: 30 Total: 141	F 0000		

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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	Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.			
F 0157 SS=D Bldg. 00	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			

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	§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 the physician was notified when there was a change in condition and medication error by omission for 1 of 5 residents reviewed for physician notification. (Resident B) Findings include: The clinical record review for Resident B was reviewed on 8/4/15 at 11:03 a.m. Diagnoses for the resident included, but were not limited to, dementia, acute pain, hypertension, history of breast cancer in situ, and venous insufficiency. 1. A nursing note dated 7/13/15 at 10:11 a.m., the nurse indicated the following: " This nurse in to administer medication to resident et resident stated that she needed to go to this resident to toilet, this nurse assisting resident to toilet when resdent [sic] sat on toilet et became limp, this nurse caling [sic] resident's name et touching her et resident not responding with eyes wide open, DCD [Direct Care	F 0157	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B: clinical record has been reviewed and resident no longer utilizes the support device for her knee. All appointments for resident B have been scheduled, transport arrangements made and placed on the calendar. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents that utilize brace/support devices have the potential to be affected by the	09/04/2015

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	Director] summoned, 911 called per DCD's request, call, placed to CHA [hospital] ER et report given, (family member) notified, 911 EMT's arrived et resident transported to hospital at 9:45 a.m." The note lacked any documentation of physician notification. Review of the nursing notes from 6/30/15 through 8/4/15 lacked any documentation of the physician being notified of the change in condition for Resident B. 2. Review of the Medication Administration Record for July 2015 indicated all doses of Keflex had been given to Resident B. An order for Keflex 500 mg by mouth twice daily was started on 7/1/15 and was to be given for 7 days. Review of the investigation report indicated medications were found in Resident B's bed on 7/8/15 while family was visiting. Two white pills and one green pill were found in the resident's bed. The two white pills were later identified as Keflex (an antibiotic medication). Review of the nursing notes from 6/30/15 through 8/4/15 lacked any documentation of the incident related to medications being found in the resident's bed. The nursing notes lacked any documentation		same deficient practice. The clinical records for all residents with brace/support devices have been reviewed to ensure there is physician notification, orders for use, and plan of care is correct. All residents that have appointments scheduled and require transport arrangements to be made by the facility have the potential to be affected by the same deficient practice. The clinical records for all residents have been reviewed from the last 30 days to ensure all transport arrangements have been made and update on the unit calendar. **What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;**	

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	of physician notification of the event. During an interview on 8/5/15 at 1:53 p.m., the Director of Nursing (DON) indicated the incident was investigated. "In our investigation we were unable to identify exactly what day the resident did not receive the medications. We don't know which nurse was responsible. We re-educated all nurses on that unit in regards to medication administration, specific to not leaving medications unattended at the bedside. It isn't documented that the MD was ever notified of the event." On 8/5/15 at 3:30 p.m., the DON provided a copy of the guidelines used by the facility for physician notification. The guidelines were undated and titled "INTERACT Version 4.0, Tool Change in Condition: When to report to the MD/NP[Nurse Practitioner]/PA [Physician Assistant]". The guidelines indicated the following: "Immediate Notification - Any symptom, sign or apparent discomfort that is Acute or Sudden in onset , and a marked change (i.e. more severe) in relation to the usual symptoms and signs , or Unrelieved by measures already prescribed. ... Fainting - Sudden loss of consciousness...		Licensed Nursing staff has been educated on the process for obtaining a physician order for brace/support device use to include physician notification and orders for use. The Director of Care Delivery or designee will review those residents with mobility assistive devices 5x weekly x2 weeks then monthly thereafter. Licensed Nursing staff has been educated on the process for setting up transportation arrangements for resident appointments. The Director of Care Delivery or designee will review all scheduled appointments 5x weekly to ensure transportation arrangements have been made. **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;**	

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	A current policy dated 12/2014 titled "Medication and Treatment Administration Guidelines" indicated the following: "General ...Medications are administered in accordance with standards of practice and state specific and federal guidelines. ..." This federal tag relates to Complaint IN00178701. 3.1-5(a)(2)		Audit findings will be presented to the QA&A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&A Committee will review findings and determine the need for further monitoring and/or education per the QA&A process	
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.			

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	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure a resident's care plans provided the necessary interventions to prevent falls for 1 of 3 residents reviewed for falls. (Resident E). Findings include: The clinical record review for Resident E was reviewed on 8/5/15 at 8:36 a.m. Diagnoses for the resident included, but were not limited to, congestive heart failure, hypertension, insomnia, chronic pain, Alzheimer's disease, and dementia. Review of a fall report dated 7/21/15 at 9:15 a.m., indicated Resident E was ambulating in the hallway without using a walker. Resident E fell on her buttocks and bumped her head on the wall. Resident E indicated she slipped. The fall was witnessed. No injuries were noted.	F 0279	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident E : Clinical record has been reviewed and care plan updated to reflect residents current condition and intervention needs. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents that utilize mobility devices have the potential to be	09/04/2015

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	A current care plan dated 4/21/14 and revised 7/21/15 for falls, indicated the following intervention was added after Resident E's fall on 7/21/15: "Make sure resident is using walking [sic] while ambulating." During an interview on 8/4/15 at 12:52 p.m., LPN #6 indicated Resident E self toilets and ambulates through the unit freely. LPN #6 witnessed the fall on 7/21/15 and indicated Resident E was ambulating without her walker. "She didn't have her walker and fell on her bottom. I couldn't get to her fast enough. I had just given her her medications." During an interview on 8/5/15 at 4:10 p.m., the Director of Nursing (DON) indicated Resident E should not ambulate without the use of the walker. "She shouldn't be walking without it. She has had that walker since she has been here. I don't know why it was missed on the care plan. There should have been an intervention related to the use of the walker." During an observation on 8/5/15 at 7:30 a.m., Resident E ambulated to breakfast using her walker. Resident E's ambulated with short jerky steps. After breakfast Resident E retrieved the walker and		affected by the same deficient practice. The clinical records for all residents with mobility devices have been reviewed to ensure the care plan is current with the interventions for use of the mobility device. **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 has been educated on the Care Plan Guidelines to include focus on all interventions in place relating to mobility assistive devices. The Director of Care Delivery or designee will review those residents with mobility assistive devices 5x weekly for two weeks, then weekly x 2 weeks them monthly thereafter. Additionally, all residents that have had a fall will be reviewed 5x weekly to ensure appropriate interventions are in place and are reflected in	

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	ambulated throughout the unit freely. This federal tag relates to Complaint IN00178701. 3.1-35(b)(1)		the plan of care. **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 QA&A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&A Committee will review findings and determine the need for further monitoring and/or education per the QA&A process **By what date the systemic changes will be completed? September 4, 2015**	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility			

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	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 had transportation to necessary medical appointments outside the facility for 1 of 5 residents reviewed for accommodation of needs (Resident B). The facility further failed to address the use of treatment for knee pain with elastic support provided by the family with the physician, and receive orders for appropriate care interventions for pain and swelling for 1 of 5 residents reviewed. (Resident B) Findings include: The clinical record review for Resident B was reviewed on 8/4/15 at 11:03 a.m. Diagnoses for the resident included, but were not limited to, dementia, acute pain, hypertension, history of breast cancer in situ, and venous insufficiency. 1. Review of Resident E's physician orders on 8/4/15 at 11:03 a.m. indicated Resident B had an appointment with the Oncology physician on 7/23/15 at 2:30 p.m. Resident B did not make the	F 0309	**Tag F 309 provide care and services for highest well being** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B: clinical record has been reviewed and resident no longer utilizes the support device for her knee. All appointments for resident B have been scheduled, transport arrangements made and placed on the calendar. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents that utilize brace/support devices have the potential to be affected by the same deficient practice. The clinical records for all residents with brace/support devices have been reviewed to ensure there is physician notification, orders for use, and plan of care is correct. All residents that have appointments scheduled and require transport arrangements to be made by the facility have the potential to be affected by the same deficient practice. The clinical records for all residents have been reviewed from the last	09/04/2015

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	appointment due to transportation not being set up in a timely manner. During an interview on 8/4/15 at 10:11 a.m., LPN #5 indicated the appointments were kept on a calendar at the nursing station. LPN #5 found the calendar and noted an appointment on 7/23/15 at 2:30 p.m. for Resident B to see the Oncology physician. No transportation was noted on the calendar. LPN #5 indicated whoever put the appointment on the calendar should have made arrangements for transportation at that time. During an interview on 8/5/15 at 10:20 a.m., the Director of Nursing indicated "Transportation should be set up at the time the appointment was put on the calendar. I am not sure why it was missed." The DON indicated she did not know who put the appointment on the calendar. The DON indicated the facility had no written policy for making transportation arrangements, but did have a process as follows: "Transportation process: Arrange transportation for appointment. Place information on calendar: where will they go (address), who will be taking them (family or transport van), time of appointment and pick up time." 2. Review of the nursing notes dated		30 days to ensure all transport arrangements have been made and update on the unit calendar. **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 has been educated on the process for obtaining a physician order for brace/support device use to include physician notification and orders for use. The Director of Care Delivery or designee will review those residents with mobility assistive devices 5x weekly x2 weeks then monthly thereafter. Licensed Nursing staff has been educated on the process for setting up transportation arrangements for resident appointments. The Director of Care Delivery or designee will review all scheduled appointments 5x weekly to ensure transportation arrangements have been made. **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 QA&A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&A Committee will review findings and determine the need for further monitoring and/or	

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	6/30/15 at 9:39 a.m. for Resident B, indicated the following: "Notified per CNA (Certified Nursing Assistant) that resident's left knee appeared to be swollen, upon assessment per this nurse, noted (L) knee to be edematous with 2 small superficial open areas, resident stated that knee had swelling noted yesterday, but she didn't say anything to anybody, NP [Nurse Practitioner] notified, awaiting reply." Review of nursing notes dated 6/30/15 through 8/4/15 lacked any other documentation of the resident wearing an elastic knee support. Review of the Medication and Treatment Administration Records for June 2015 and July 2015 lacked any documentation for removal or assessment of the elastic knee support. Review of the physician orders for June and July 2015 lacked any order for the use of an elastic knee support. During an interview on 8/5/15 at 10:20 p.m., the Director of Nursing (DON) indicated Resident B had been admitted on 5/22/15 from another facility. The DON indicated the elastic support was given to the resident by a family member. The DON was unable to determine when		education per the QA&A process **By what date the systemic changes will be completed? September 4, 201**	

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	Resident B received the elastic knee support. The DON provided a copy of an order dated 5/1/15 for physical therapy to evaluate Resident B for left knee pain. The DON indicated resident B refused to see physical therapy at that time. The DON was not able to provide documentation related to the elastic knee support or Resident B's refusal to see physical therapy. The DON did not know why the order was dated 5/1/15. "IT must have been a mistake. It probably should have been 6/1/15." This federal tag relates to Complaint IN00178701. 3.1-37(a)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based observation and interview, the facility failed to provide a clean environment for 1 of 5 residents (Resident C) reviewed for clean environment. This deficient practice had the potential to effect 19 residents living on the Arcadia unit who received showers on the unit.	F 0465	**Tag 465 safe functional sanitary comfortable environment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C : Maintenance replaced the wax ring and tiles around the toilet in	09/04/2015

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MANORCARE HEALTH SERVICES	1345 N MADISON AVE ANDERSON, IN 46011

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	Findings include: The clinical record review for Resident C was reviewed on 8/4/15 at 1:00 p.m. Diagnoses for the resident included, but were not limited to, dementia Alzheimer's type, hypertension and depression. During an observation on 8/4/15 at 10:00 a.m., the Arcadia Unit shower room was noted to have a key pad lock. The bath room floor was dry with a small amount of dark brown matter speckling the floor and concentrated around the drain. No odor was noted. One barrel with soiled linens was in the room with the lid securely in place. During an interview on 8/4/15 at 10:10 a.m., LPN #6 indicated the shower room was kept locked at all times and the shower was cleaned by housekeeping once a day. During an observation on 8/4/15 10:30 a.m., housekeeping was observed cleaning the shower room. During a tour on 8/5/15 at 10:20 a.m., with the Director of Nursing to Resident C's bathroom, it was noted to have a urine odor. The floor tiles surrounding		the resident's bathroom. Shower room on the unit was deep cleaned and inspected by the environmental supervisor for thoroughness and proper sanitation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents with a toilet in their bathroom have the potential to be affected by the same deficient practice. The Maintenance Director completed a 100% audit of all toilets for function and to ensure they are free from stains or in need of repair. All residents that utilize the shower rooms have the potential to be affected by the same deficient practice. The Environmental Supervisor completed a 100% audit of all shower rooms for cleanliness and proper sanitation. **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 and certified Nursing Assistants have been educated on the process for completing work orders for Maintenance needs. Maintenance staff have been educated on conducting room environmental rounds. Housekeeping staff have been educated on the process for completing work orders with	

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

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	the toilet had dark brown stains at the toilet base. The DON indicated she would call maintenance to look at the toilet and the floor tiles. During an interview on 8/5/15 at 10:20 a.m., the Director of Nursing (DON) indicated the shower rooms were to be cleaned by nursing staff after every shower. The shower room on the Arcadia Unit was toured at this time with the DON. The room did not have an odor but the brown speckled matter was present on the floor. The DON indicated the floor did not look clean. During an interview on 8/5/15 at 3:48 p.m., the Maintenance Supervisor indicated he had looked at the toilet in Resident C's room. The Maintenance Supervisor indicated the wax ring and tiles needed to be replaced. The maintenance Supervisor indicated the repairs had been completed. The maintenance Supervisor also indicated nursing and housekeeping staff should send a work order to alert the maintenance department of needed repairs. The Maintenance Supervisor indicated the work orders through May 2015 had been reviewed and no work order for Resident C's room had been placed.		focus on checking the toilets for leaks and stains around the base. Maintenance Director of designee will complete room environmental rounds 5x weekly x 2 weeks and then monthly thereafter. Licensed Nursing staff and certified Nursing Assistants have been educated on the guidelines for cleaning shower/bathing equipment following care and use. Housekeeping staff have been educated on the process for cleaning the shower rooms to include thoroughness and proper sanitation. The Environmental Supervisor will conduct shower room environmental rounds 5x weekly x 2 weeks at various times to ensure proper cleaning and sanitation. **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 QA&A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&A Committee will review findings and determine the need for further monitoring and/or education per the QA&A process **By what date the systemic changes will be completed? September 4, 2015**	

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	This federal tag relates to Complaint IN00179263. 3.1-19(f)			