STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/16/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK		STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN46123	

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F0000	This visit was for the Investigation of Complaints IN00099662 and IN00099143. Complaint IN00099143 - Unsubstantiated due to lack of evidence. Complaint IN00099662 - Substantiated. Federal/state deficiencies related to the allegation are cited at F225 and F226. Survey dates: November 14, 15 & 16, 2011 Facility number: 000231 Provider number: 155338 AIM number: 100267900 Survey team: Christi Davidson, RN-TC Census bed type: SNF: 34 SNF/NF: 81 Total: 115 Census payor type: Medicare: 23 Medicaid: 65 Other: 27 Total: 115	F0000	The facility is submitting this Plan of Correction because of requirement by Federal Regulation. The submission of this plan does not constitute agreement with or an admission on the part of Manor Care Health Services – Prestwick as to the accuracy of the statements or conclusions contained in the statement of deficiencies.	

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: 6 Supplemental sample: 2 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on November 17, 2011 by Bev Faulkner, RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report to the appropriate state agencies an incident of inappropriate sexual behavior in 1 of 4 facility abuse investigations reviewed. This involved	F0225	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents E & F were both re-assessed with no further	12/15/2011

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	Residents E and F. Findings include: During the end of day conference on 11/14/11 at 5:00 p.m., the Administrator was requested to provide facility investigations to determine if the facility implemented the proper procedures for allegations of abuse. On 11/15/11 at 9:00 a.m., the Administrator provided four facility investigations to review. On 11/15/11 at 12:30 p.m., an investigation with an incident date of 8/30/11 was reviewed. The facility incident report, dated 8/30/11 at 5:57 p.m., indicated, "...Pt [patient] was accused by another pt of 'grabbing her arm and touching himself inappropriately with it.'...." The incident report indicated the location of the incident was in the hallway. The incident report indicated Resident #F was placed on 1 on 1 supervision, the physician was notified and Resident #F's family member was notified. A facility Investigation Report, dated 8/30/11, indicated the incident was reported to the Administrator at 4:10 p.m. The "Summary of Critical Information		findings that they were affected by the practice. **How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?** All residents have the potential to be affected. Any allegation of abuse, neglect or exploitation will be will be reported to the Indiana State Department of Health as required by th federal and state regulations and investigated. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All incidents involving the investigation abuse, neglect or exploitation will be reviewed at the time of the investigation by the Administrator or designee and in an ad hoc QA meeting to ensure compliance with the relevant federal and state regulations as well as the internal facility guidelines for reporting allegations of abuse, neglect and exploitation. **How will the corrective action(s) be monitored to ensure the deficient practice does not recur?** All incidents involving allegations of abuse, neglect or exploitation will be reviewed at the time of the incident or allegation, during the facility's investigation by the Administrator or designee, and in the monthly QA meeting to ensure	

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	Obtained During Investigation:" indicated, "Male resident had his clothes intact...Male resident took her hand and placed over private part [sign for with] clothes intact. Female resident pulled hand away...." This report indicated Resident #E was interviewed at 4:30 p.m. on 8/30/11. Documentation of the interview conducted by the Social Service Director on 8/30/11 indicated Resident #E indicated, "...he grabbed my hand a [sic] rubbed my hand in his private area...." A nurses note for Resident #F, dated 08/30/11 at 7:30 p.m., indicated, "...pt was accused by another pt of 'grabbing her hand and touching himself inappropriately [sign for with] it...." A care plan for Resident #F, dated 08/30/11, indicated a focus of "Inappropriate Sexual Behavior...." The goals indicated Resident #F would carry out sexual behavior in the privacy of his room. The interventions included, but were not limited to provide privacy, provide supervision in social gatherings, and administer medication as ordered. The Alert Charting Log, dated 08/30/11, indicated Resident #F was being monitored due to inappropriate behaviors.		compliance with the relevant federal and state regulations as well as the internal facility guidelines for reporting allegations of abuse, neglect and exploitation.	

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	A physician's order for Resident #F, dated 08/30/11, indicated labs were ordered including, but not limited to a urinalysis, urine culture and sensitivity, and a complete blood count. A Social Service note for Resident #F, dated 08/31/11, indicated, "...he was placed on one on one at that time...Labs were requested...Psych was in the building...." A Mental and Behavioral Health Visit Note for Resident #F, dated 08/30/11, indicated he was evaluated because staff reported the resident had inappropriately touched a female resident. During an interview on 11/15/11 at 12:40 p.m., the Administrator indicated he did not report the incident to The Indiana State Department of Health (ISDH). During an interview on 11/15/11 at 12:45 p.m., the Director of Nursing (DoN) indicated she did not report the incident to ISDH. She indicated she did do an internal investigation. This federal tag relates to Complaint IN00099662. 3.1-28(c)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their policies and procedures for reporting allegations of abuse to state agencies in 1 of 4 facility investigations reviewed. This involved Resident E and F. Findings include: During the end of day conference on 11/14/11 at 5:00 p.m., the Administrator	F0226	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents E & F were both re-assessed with no further findings that they were affected by the practice. **How will other residents having the potential to be affected by the same deficient practice be identified and what actions will be taken?** All residents have the potential to be affected. The Administrator	12/15/2011

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	was requested to provide facility investigations to determine if the facility implemented the proper procedures for allegations of abuse. On 11/15/11 at 9:00 a.m., the Administrator provided four facility investigations to review. On 11/15/11 at 12:30 p.m., an investigation with an incident date of 8/30/11 was reviewed. The facility incident report, dated 8/30/11 at 5:57 p.m., indicated, "...Pt [patient] was accused by another pt of 'grabbing her arm and touching himself inappropriately with it.'...." The incident report indicated the location of the incident was in the hallway. The incident report indicated Resident #F was placed on 1 on 1 supervision, the physician was notified and Resident #F's family member was notified. A facility Investigation Report, dated 8/30/11, indicated the incident was reported to the Administrator at 4:10 p.m. The "Summary of Critical Information Obtained During Investigation:" indicated, "Male resident had his clothes intact...Male resident took her hand and placed over private part [sign for with] clothes intact. Female resident pulled hand away...." This report indicated		and Director of Nursing have been re-educated on federal and state guidelines for reporting and investigating allegations of abuse, neglect and exploitation. Any reports that constitute an allegation of abuse, neglect or exploitation, pursuant to federal and state regulations and guidelines, will be reported to the Indiana State Department of Health by the Administrator or designee. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Administrator and Director of Nursing have been re-educated on federal and state guidelines for reporting and investigating allegations of abuse, neglect and exploitation. Any reports that constitute an allegation of abuse, neglect or exploitation will be reported to the Indiana State Department of Health by the Administrator or designee. **How will the corrective action(s) be monitored to ensure the deficient practice does not recur?** All incidents involving allegations of abuse, neglect or exploitation will be reviewed at the time of the incident or allegation, during the facility's investigation by the Administrator or designee, and in the monthly QA meeting to ensure compliance with the relevant federal and state regulations as	

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	administrator is responsible for the investigating, reporting and coordinating of the investigation process of any alleged or suspected abuse...Report/Respond...are reported immediately to the administrator of the center and to other officials in accordance with state law...'immediately' means as soon as possible, but ought not exceed 24 hours after discovery of the incident...." This federal tag relates to Complaint IN00099662. 3.1-28(a)			