

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 01/24/2014
--	---	--	---

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

(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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00141777, IN00140806, and IN00141419.</p> <p>Complaint IN00141777 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0282.</p> <p>Complaint IN00141419 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00140806 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: January 16, 17, 21, 22, 23, and 24, 2014.</p> <p>Facility number: 000151 Provider number: 155247 AIM number: 100284060</p> <p>Survey team: Marcy Smith, RN-TC Patti Allen, SW Diana Zgonc, RN</p> <p>Census bed type: SNF: 42</p>	F000000	<p>This Plan of Correction constitutes the center's Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana Department of Health. Preparation and execution of this response and the 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. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	
---------	---	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155247	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>SNF/NF: 75 Total: 117</p> <p>Census payor type: Medicare: 22 Medicaid: 58 Other: 37 Total: 117</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 27, 2014; by Kimberly Perigo, RN.</p>				

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 01/24/2014
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227		
(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	
F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure nutrition care plans were updated for 2 of 3 residents reviewed for weight loss in a sample of 4 who met the criteria for review of significant weight loss. (Residents #12 and #92)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #12 was reviewed on 1/23/14 at 8:41 a.m.</p> <p>Diagnoses for Resident #12 included, but were not limited to,</p>	F000280	<p>F280 Right to Participate Planning Care-Revise CP; It is the practice of Manor Care Indy South to update care plans within 7 days of a comprehensive assessment. What corrective action will take place for those residents found to be affected by the deficient practice? Neither resident #12 or #92 were adversely affected by the stated deficiency. Both residents #12 and #92 have had their care plans updated by the dietitian. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? A complete audit of all nutritional care plans</p>	02/11/2014	

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 01/24/2014	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>chronic airway obstruction, Alzheimer's disease, heart failure, and anxiety.</p> <p>A nutrition care plan for Resident #12, created on 9/25/13, and reviewed on 11/1/13, indicated the resident was at risk for potential weight loss related to therapeutic, mechanically altered diet and a diagnosis of depression. The goal was the resident, "Will experience no significant weight change."</p> <p>A dietary note, dated 11/4/13, indicated Resident #12 had a 11.7% weight loss in 30 days. A possible cause was food "intake, poor." New dietary interventions were put in place at that time.</p> <p>The care plan was not updated to reflect the resident had a significant weight change.</p> <p>In an interview with the dietician on 1/23/14 at 10:50 a.m., she indicated the resident was currently at "normal" weight, according to the resident's daughter. The dietician indicated she should have updated the care plan to reflect the residents weight loss and changed the goal to, "Resident will not experience any further weight loss."</p>		<p>has been completed by the dietitian to identify any other residents who may have a need to update a care plan goal or intervention. Any patients identified needing updated goals or interventions have had those goals and interventions updated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Nutritional care plans of all residents identified with weight loss will be reviewed weekly by the dietitian to identify any need to update the care plan or the interventions. The dietitian was in-serviced on the need for updating care plan goals and interventions. How will the corrective actions be monitored to ensure they do not occur again? The dietitian will document on a QA tool the residents she reviews and updates to care plans that have been made. 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 weekly. By what date will the changes occur? 2/11/2014</p>				

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 01/24/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. The clinical record of Resident #92 was reviewed on 1/23/14 at 2:06 p.m.</p> <p>Diagnoses for Resident #92 included, but were not limited to depressive disorder, heart failure, chronic airway obstruction, and anxiety.</p> <p>A nutrition care plan for Resident #92, initiated 11/25/09 and reviewed 11/1/13, indicated a focus of potential weight loss related to the use of a mechanically altered diet. The goal was the resident would have no significant weight change.</p> <p>A review of Resident #92's weights indicated on 11/1/13 she weighed 143.5, and On 12/7/13 she weighed 133.6.</p> <p>A dietary note dated 12/9/13 indicated, "resident with a 6.9% [weight] loss [in] 1 month - significant." New dietary interventions were put in place at that time.</p> <p>During an interview with the dietician on 1/23/14 at 3:30 p.m., she indicated she should have updated Resident #92's care plan to reflect</p>			

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 01/24/2014
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227		
(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	
F000282 SS=D	<p>the resident's actual weight loss.</p> <p>During an interview with the Director of Nursing on 1/23/14 at 2:30 p.m., she indicated residents who experienced significant weight loss were discussed at the facility morning meeting and then the appropriate care deliverer was supposed to update the care plan.</p> <p>A facility policy, received from the dietician on 1/23/14 at 11:47 a.m., titled, "Weight Management Practice Guide," dated 02/2011, indicated, The care plan is routinely reviewed as needed, and updated to reflect the patient's current status and care delivery needs."</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure</p>	F000282	F282 Services by Qualified Persons/per Care Plan; It is the practice of Manor Care Indy	02/11/2014	

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 01/24/2014
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a continuous positive airway pressure (c-pap) machine was utilized as ordered by the physician (Resident #B) and laboratory blood tests were performed as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications. (Resident #1)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #1 was reviewed on 1/22/14 at 10:31 a.m..</p> <p>Diagnoses for Resident #1 included, but were not limited to, stroke and seizures.</p> <p>A recapitulated physician's order for January, 2014, with an original order date of 12/4/06, indicated Resident #1 was to receive Dilantin, (an anti-seizure medication) 300 milligrams, (mgs.....) every evening.</p> <p>A recapitulated physician's order for January, 2014, with an original date of 11/30/12, indicated Resident #1 was to have his Dilantin level checked every 3 months, in August, November, February, and May.</p> <p>A Dilantin level for August, 2013, was not found in the resident's</p>		<p>South to provide services by qualified persons in accordance with each resident's written care plan. What corrective action will take place for those residents found to be affected by the deficient practice? Resident #B no longer resides in the facility, but was not adversely affected by the failure to apply the CPAP. Residents #1 did not experience any adverse effect as a result of missing a lab in August. Resident #1 had the lab drawn in November 2013. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? There are no other residents in the facility who have orders for a CPAP machine. A complete audit of all lab orders has been completed to identify any other resident who has the potential to miss a lab draw. A list of current orders was given to the attending physician and nurse practitioner to review for any orders which needed to be changed. The corrected list was provided to the contracted lab service. 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 and ADONs will be in-serviced regarding implementation of all physician orders at the time of admission, including CPAP orders. ADONs will be in-serviced</p>		

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 01/24/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>record. Further information was requested from the Director of Nursing (DON) on 1/22/14 at 2:00 p.m. On 1/23/14 at 11:55 a.m., the DON indicated the laboratory had Resident #1 scheduled for a Dilantin level blood draw every 6 months, not every 3 months as ordered.</p> <p>A Dilantin level was drawn in November, 2013, as ordered, and it indicated a "low" Dilantin level in Resident #1's blood. On 11/6/13, the physician ordered the resident to receive an extra 100 mg of Dilantin in the evening, in addition to his morning dose. Physician progress notes from 11/14/13, indicated the resident had not had any seizure activity since January 2013.</p> <p>2. The clinical record for Resident # B was reviewed on 1/22/14 at 12:30 P.M.</p> <p>The resident was admitted on 12/14/13 and discharged on 12/16/13.</p> <p>Diagnoses for Resident # B included, but were not limited to, chronic respiratory failure, chronic obstructive pulmonary disease, sleep apnea, macular degeneration,</p>		<p>regarding the process for verifying labs were drawn and that results placed in the medical record. How will the corrective actions be monitored to ensure they do not occur again? All new admissions will be audited for implementation of physician orders and recorded on a QA tool by the DON or designee. On a separate QA tool, a sample of resident labs orders will be tracked for draw and placement in medical record. 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 weekly. By what date will the changes occur? 2/11/2014</p>	

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 01/24/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reflux, A-fib, gout, anemia, hypertension, hepatitis B, dysthymias, anxiety, hypothyroidism, obesity, osteoarthritis, osteoporosis, muscle weakness, hyperlipidemia, and venous thrombosis.</p> <p>Review of the physician's orders for December 2013, indicated the resident required C-pap (continuous positive airway pressure for sleep apnea) during sleeping hours.</p> <p>The medication administration record (MAR) lacked documentation the C-PAP was applied as ordered on December 14 and 15, 2013.</p> <p>During an interview with the resident's daughter on 1/22/14 at 11:44 A.M., she indicated the facility did not utilize the C-pap machine for her mother's sleep apnea on 12/14 or 12/15/13.</p> <p>During an interview with the Director of Nursing on 1/24/14 at 10:23 A.M., she indicated there were 2 nurses who were given a final written warning for not placing the C-pap on in the evening shift or the night shift.</p> <p>This Federal tag relates to Compliant IN00141777.</p>			

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 01/24/2014
--	---	--	---

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

(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
	3.1-35(g)(2)			

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 01/24/2014
--	---	--	---

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

(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
F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure a laboratory blood test, as ordered by the physician, was done, to verify a resident was on the appropriate therapeutic dose of seizure medication, for 1 of 5 residents reviewed for unnecessary medications. (Resident #1)</p> <p>Findings include:</p>	F000329	F329 Drug Regimen is Free from Unnecessary Drugs; It is the practice of Manor Care Indy South not to administer unnecessary drugs.What corrective action will take place for those residents found to be affected by the deficient practice? Residents #1 did not experience any adverse effect as a result of missing a lab in August. Resident #1 had the lab drawn in November 2013. How other residents having the potential to be affected by the same deficient practice will be identified and	02/11/2014

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 01/24/2014
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The clinical record of Resident #1 was reviewed on 1/22/14 at 10:31 a.m..</p> <p>Diagnoses for Resident #1 included, but were not limited to, stroke and seizures.</p> <p>A recapitulated physician's order for January, 2014, with an original order date of 12/4/06, indicated Resident #1 was to receive Dilantin, (an anti-seizure medication) 300 milligrams, (mgs..) every evening.</p> <p>A recapitulated physician's order for January, 2014, with an original date of 11/30/12, indicated Resident #1 was to have his Dilantin level checked every 3 months, in August, November, February, and May.</p> <p>A Dilantin level for August, 2013, was not found in the resident's record. Further information was requested from the Director of Nursing (DON) on 1/22/14 at 2:00 p.m. On 1/22/14 at 3:00 p.m., the DON indicated the laboratory had Resident #1 scheduled for a Dilantin level blood draw every 6 months, not every 3 months as ordered.</p> <p>A Dilantin level was drawn in November, 2013, as ordered, and it</p>		<p>what corrective action will be taken?A complete audit of all lab orders has been completed to identify any other resident who has the potential to miss a lab draw. A list of current orders was given to the attending physician and nurse practitioner to review for any orders which needed to be changed. The corrected list was provided to the contracted lab service. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?ADONs will be in-serviced regarding the process for verifying labs were drawn and that results placed in the medical record. How will the corrective actions be monitored to ensure they do not occur again?A sample of resident labs orders will be tracked for draw and placement in medical record on a QA tool by the DON or designee. 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 weekly.By what date will the changes occur? 2/11/2014</p>		

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 01/24/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated a "low" Dilantin level in Resident #1's blood. On 11/6/13, the physician ordered the resident to receive an extra 100 mg of Dilantin in the evening, in addition to his morning dose. Physician progress notes from 11/14/13, indicated the resident had not had any seizure activity since January 2013.</p> <p>3.1-48(a)(3)</p>			