

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  03/03/2016
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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PRESTWICK	STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00194540.</p> <p>Complaint IN00194540 - Substantiated. Federal/State deficiencies related to he allegations are cited at F 309 and F 323.</p> <p>Survey dates: March 2, 3, 2016</p> <p>Facility number: 000231 Provider number: 155338 AIM number: 100267900</p> <p>Census bed type: SNF: 20 SNF/NF: 60 Total: 80</p> <p>Census payor type: Medicare: 8 Medicaid: 45 Other: 27 Total: 80</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 3/7/16 by</p>	F 0000	<p>This plan of correction is submitted as required under Stateand Federal Regulations. The submission of this plan of correction does notconstitute an admission on the part of the facility, as to the accuracy of thesurveyors findings, that those findings constitute a deficiency, and that thescope and severity of cited deficiency has been correctly applied. This plan ofcorrection also constitutes the facility's credible allegation of compliance.</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.

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F 0309 SS=G Bldg. 00	<p>29479.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure staff utilized precautions to avoid moving a body part with a suspected fracture when a mechanical lift was used to move a resident who fell resulting in a displaced fracture of the humerus (long bone in the arm) for 1 of 3 residents reviewed for quality of care related to a suspected fracture (Resident B).</p> <p>Finding includes:</p> <p>The record for Resident B was reviewed on 3/2/16 at 10:00 a.m. Resident B's diagnoses included muscle weakness, osteoporosis, and dementia.</p> <p>A Nursing Progress Note, dated 2/26/16 at 11:45 a.m., indicated the nurse heard a resident fall in the hallway and found the resident face down on the floor with a moderate amount of blood from a laceration on her chin, the DON (Director</p>	F 0309	<p>1. Resident B was sent to the hospital had surgery to repair fracture. Resident was then sent to Behavioral Health to address agitation, and anxiety that contributed to recent falls. Resident has returned to the facility and is currently receiving one to one supervision.</p> <p>2. This f tag has the potential to affect residents that have a fall event.</p> <p>3. Review Interact 4.0 as it relates to post fall assessment and fall practice guides Educate licensed staff on following interact 4.0 as it relates to the post fall assessment and fall practice guides Educate facility staff on taking appropriate precautions when a resident has fallen. This education will include proper assessment by licensed nurse, guidelines for moving an injured resident, and proper notification of family and Doctor.</p> <p>4. RN/LPN and facility Staff education will be conducted by completion date, upon hire and at</p>	03/28/2016			

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	<p>of Nursing) approached and instructed the nurse to call the physician and 911. The POA (Power of Attorney) was also notified.</p> <p>A Nursing Progress Note, 2//26/16 11:45 a.m., indicated Resident B was lying flat on her face with 2 staff members present. A small pool of blood was noted under the resident on the right side. The resident was alert and speaking. The nurse assessed the resident for pain, the resident indicated she had pain in her right arm. The nurse and staff then turned the resident over onto her back while supporting her joints and placed a pillow under her head to see where the blood originated. A small laceration was noted to her chin and there were no other visible injuries. "Visual assessment of extremities showed symmetrical lower and upper extremities." The nurse then attempted to assess ROM (range of motion) of extremities. The assessment of lower extremities was without distress to the resident and the resident denied pain. The resident was asked to raise her arms, and was able to raise her left arm without difficulty, but her right arm only slightly and complained of shoulder pain. Pressure was applied to her chin. "Resident was assisted up x's 2 [by 2 staff members] using hoyer lift [mechanical lift] ems [emergency medical services]</p>		<p>least annually.</p> <p>5.DON or designee will be complete audits x5weekly for 4 weeks then x3 weekly for 4 week on post fall assessments. Reviewed for trends and to identify any opportunities for additional training. This process will be reported to the QAAcommittee monthly to monitor trends and evaluate training processes. and the committee will determine if further monitoring will be required Completion Date 3/28/2016IDR Request F-tag 309 According to the 2567 this F-tag was citedbecause the facility failed to ensure staff utilized precautions to avoidmoving a body part with a suspected fracture. The facility respectfully denies and disputesthe allegation that it failed to ensure staff utilized precautions when movinga body part with suspected injury. This resident was admitted to the facility12/14/2015. Resident was admitted with a diagnosis of mild intellectual disorder.Her mother was also in the facility for care. Due to this resident being very anxiousand with cognitive impairment she did not understand reassurance from staffthat her mother was ok. Staff met withmother and other family members and it was agreed that moving the resident inwith her mother would be beneficial to her. However, after approximately one</p>				

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	<p>had arrived resident was transferred to gurney via hooyer lift."</p> <p>The hospital emergency department examination report, 2/26/16, indicated "Upper extremity exam included findings of inspection abnormal, deformity present..."</p> <p>The hospital Radiology Report, 2/26/16, indicated "There is a displaced fracture of the proximal shaft of the right humerus. There is overriding with shortening."</p> <p>During an interview with the DON on 3/2/16 at 12:30 p.m., she indicated she had gone to the resident and when she (DON) was assessing Resident B's ROM, Resident B could barely lift her right arm and said her arm and shoulder hurt. The DON indicated she had asked the Unit Manager to get vital signs, and told her not to take the blood pressure in her right arm because Resident B said it hurt. "Then we got her up on the hooyer [lift], the EMTs [emergency medical team] arrived and we lowered her onto their stretcher."</p> <p>During an interview with RN #1 on 3/2/16 at 9:20 a.m., she indicated the resident should not have been moved off the floor when staff was instructed to use the mechanical lift to move the resident</p>		<p>totwo weeks the resident was even more disruptive to care and more anxious. Resident then was moved to the other side of the facility, however residentremained very anxious and worried about her mother constantly. Staff wouldescort her back to visit her mother at least 6 or 7 times a day. On 2/05resident stated she did not want the wheelchair and we could not make her dosomething she didn't want to do. On2/26/2016 this resident got out of bed and was ambulating down the hall with awalker with the intent of seeing her mother. At that time the resident wasobserved by staff from a distance as she fell forward hitting her chain on thefloor. Staff came to assist resident and asked her about any pain she washaving. Resident complained about pain in her right arm area. Resident didcomplain of pain in this area previous to this fall the mobile x-ray wasnegative at that time. As noted in the 2567 before moving theresident the DON assessed the resident for injury as outlined in interact 4.0and the fall practice guide (see attached). Based on that assessment the DONinstructed the staff to not take the blood pressure from that arm due topossible injury. The 2567 and the attached nurses note showed that the DON tooksteps to protect the injured arm while getting the resident up</p>				

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	<p>and clean her up.</p> <p>During an interview with RN #2 on 3/2/16 at 11:20 a.m., she indicated she heard the resident fall and indicated the resident was crying in pain. She indicated the DON instructed the CNA to get the resident up with the mechanical lift. RN#2 indicated an injured resident should not have been moved.</p> <p>CNA #3 was interviewed on 3/2/16 at 11:45 a.m. She indicated she saw Resident B fall, but was too far away to reach her. She indicated Resident B kept crying "I'm hurt, I'm hurt." She indicated the DON told her everyone who falls should be picked up off the floor by the (mechanical) lift.</p> <p>On 3/2/16 at 1:20 p.m., CNA #4 was interviewed. She indicated she did not think you were supposed to get someone hurt off the floor. She indicated Resident B was complaining of pain.</p> <p>The "Falls Practice Guide Flowchart" and "Care Path Falls" provided by the DON on 3/2/16 at 1:30 p.m. and identified as the current protocol for care of a resident who fell indicated an initial nursing evaluation for injury and/or mental status changes with a pathway of "...DO NOT move off floor until complete exam has</p>		<p>from the floor. It must also be noted that per a CNA witness statement that was assisting with getting the resident she also immobilized the arm of the resident by placing the arm across the abdomen and holding it there to make sure it remained stable. The facility followed the Interact 4.0 tool and the fall practice guide in assessing and moving the resident with suspected injury. The facility did in fact use precautions to prevent further injury after the fall. There is no evidence that moving this resident caused further injury. As evidenced by the statement in the 2567, the nursing documentation, the witness statement of a staff member that was present the facility followed the guidelines to stabilize the fracture and there was no actual harm to the resident. The facility respectfully denies and disputes the allegation that it failed to ensure staff utilized precautions when moving a body part with suspected injury and furthermore supports that the injury (fracture) was caused by the fall the resident suffered and not due to any actions the staff took after the fall occurred. The facility respectfully requests that the citation as it related to F309 be deleted.</p>		

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F 0323 SS=G Bldg. 00	<p>been performed" and the next pathway was "Suspected fracture or new bone deformity" and indicated to notify MD (Medical Doctor or NP (Nurse Practioner) or PA (Physician Assistant).</p> <p>This federal tag relates to Complaint IN00194540.</p> <p>3.1-37(a)</p> <p>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 record review and interview, the facility failed to implement and evaluate efficacy of interventions to prevent a resident with an intellectual disability from falling, resulting in a fractured humerus (long bone in the arm). Additionally the facility failed to ensure adequate supervision to prevent the resident from removing the splint/immobilizer from the fractured arm, resulting in hospitalization and surgical repair of the fracture for 1 of 3 residents reviewed for accident supervision (Resident B).</p> <p>Finding includes:</p>	F 0323	<p>1. Resident B was sent to the hospital had surgery to repair fracture. Resident was then sent to Behavioral Health to address agitation, and anxiety that contributed to recent falls. Resident has returned to the facility and is currently receiving one to one supervision. The care plan for this resident has been reviewed and updated to reflect falls interventions put in place for this resident.</p> <p>2. This f tag has the potential to affect all residents with Diagnoses of intellectual disability at risk for falls.</p> <p>3. These residents will have their fall assessment reviewed and updated if needed. The care plan</p>	03/28/2016

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	<p>The record for Resident B was reviewed on 3/2/16 at 10:00 a.m. Resident B's diagnoses included muscle weakness, osteoporosis, dementia, and mild intellectual disability.</p> <p>The care plan, dated 12/15/15, for Resident B indicated she was at risk of falls. Interventions included, but were not limited to, encourage to transfer and change positions slowly, assist to transfer and ambulate as needed, and re-evaluate medications. A psychiatrist evaluation was added to interventions on 1//416 due to increased anxiety and flighty ideas and the plan was revised on 1/28/16 to provide non skid shoes. On 2/22/16 new interventions for frequent toileting, reminders for allowing staff to assist her, and reinforce using the call light were added. Interventions of storing the resident's walker outside her room when not in use, comforting the resident when she requested to see her mother, and non-slip socks were added to the plan on 2/26/16. The care plan did not address increased monitoring of every 30 minutes and the resident's noncompliance with using the call light and waiting for assistance.</p> <p>A Nursing Progress Note, dated 2/26/16 at 11:45 a.m., indicated the nurse heard a</p>		<p>will be updated to include identified issues with falls and interventions to address those issues. RN/LPNs will be in-serviced on completing proper assessments, and adding appropriate interventions that address the cause of the fall.</p> <p>4. RN/LPNs will be in serviced upon hire and reviewed yearly. Director of Nursing or designee will review required assessments and will complete an audit of those assessments audits x5 weekly for 4 weeks then x3 weekly for 4 week to review complete assessments, interventions, and results of those interventions. Resident behaviors will be monitored and documented within the nursing progress notes. These behaviors will be tracked and trended to determine any patterns thru the centers QA process and evaluations will be made by the IDT for possible 1 to 1 supervision reductions based on these patterns of her behaviors and any trends noted for specific times of day for these behaviors (I.E. reduce to only during waking hours). Changes to fall intervention plan include medication review by physician and pharmacist with changes per recommendations. Continue to reassure resident mother is ok, frequent toileting assistance from staff, and one to one supervision. Attempts will be made to incorporate activities and diversional activities throughout her</p>	

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	<p>resident fall in the hallway and found the resident face down on the floor with a moderate amount of blood from a laceration on her chin, the DON (Director of Nursing) approached and instructed the nurse to call the physician and 911. The POA (Power of Attorney) was also notified.</p> <p>A Nursing Progress Note, 2//26/16 11:45 a.m., indicated Resident B was lying flat on her face with 2 staff members present. A small pool of blood was noted under the resident on the right side. The resident was alert and speaking. The nurse assessed the resident for pain, the resident indicated she had pain in her right arm. The nurse and staff then turned the resident over onto her back while supporting her joints and placed a pillow under her head to see where the blood originated. A small laceration was noted to her chin and there were no other visible injuries. "Visual assessment of extremities showed symmetrical lower and upper extremities." The nurse then attempted to assess ROM (range of motion) of extremities. The assessment of lower extremities was without distress to the resident and the resident denied pain. The resident was asked to raise her arms, and was able to raise her left arm without difficulty, but her right arm only slightly and complained of shoulder pain.</p>		<p>day. Her plan of care will be reviewed and revised as necessary. After initial monitoring period all falls will be reported to the QAA committee for trending and to determine if further or ongoing monitoring is required.</p> <p>5. Results of the audits will be reported to the QAA committee. Identified trends will be reviewed/reported monthly and as needed to the QAA monthly until a lesser frequency is deemed appropriate. Completion Date 3/28/2016 IDR request F-Tag 323 According to the 2567 the facility failed to implement and evaluate efficacy of interventions to prevent a resident with an intellectual disability from falling. Resident has a diagnosis of mild intellectual disability. The resident had episodes of anxiety, and agitation. Resident is at risk for falls/r/t poor impulse control, unsteady gait, and resistance to help. The facility had a care plan in place to address these issues. The falls the resident had were directly related to the identified risks. The facility reviewed updated and added new interventions after each fall in an attempt to find an intervention that would work for this resident. The care plan was initiated on 12/15 with updates and changes to interventions occurring on 1/19, 1/28, 2/15, 2/22, 2/26, 2/27.</p>	

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	<p>Pressure was applied to her chin. "Resident was assisted up x's 2 [by 2 staff members] using hooyer lift [mechanical lift] ems [emergency medical services] had arrived resident was transferred to gurney via hooyer lift."</p> <p>The hospital emergency department examination report, 2/26/16, indicated "Upper extremity exam included findings of inspection abnormal, deformity present..."</p> <p>The hospital Radiology Report, 2/26/16, indicated "There is a displaced fracture of the proximal shaft of the right humerus. There is overriding with shortening."</p> <p>A Nursing Progress Note, 2/26/16 at 10:20 p.m., indicated Resident B returned from the hospital with a cast and sling on her right arm. The note indicated the resident attempted to get up to go to the bathroom without assistance and was unsteady and off balance.</p> <p>The next entry, dated 2/27/16 at 7:53 a.m., indicated "Resident was noted standing at bedside when noted by a CNA, nurse responded, noted resident standing with ace wrap bandage, open arm cast, &amp; sling removed, previously resident had been to hospital and diagnosed with a rt [right] humerous [sic]</p>		<p>This demonstrates the efforts of the facility to reduce the falls for this resident. On the fall dated 2/26/2016 the facility identified the root cause of the fall as the resident wanted to see her mother that resided in the facility. As noted on the care plan an intervention was put in place to reassure resident that her mother was fine and they would let her know she was asking about her. As noted in the nursing notes the facility did provide reasonable supervision to monitor resident's attempts to remove splint and ace wraps. The facility reapplied the wraps numerous times. The only other option would have been to restrain the resident. The facility checked on the resident reapplied the wraps several times, toileted and assisted the resident as needed. The resident was resistive to care and was impulsive which resulted in her removal of the ace wraps and splint. As evidenced by the continued replacement of the ace wraps and the splint staff was providing supervision to on a more than routine basis.</p> <p>The updates to the care plan show that the facility was reviewing the care plan and attempting to find interventions that would work for this resident. The citation should be deleted because the Facility complied with the intent of F323. The Facility properly assessed Resident B to identify risks, the Facility re-evaluated those risks</p>				

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	<p>fracture, this occurred at 0345 [3:45 a.m.]. appliances replaced in proper position."</p> <p>The next entry at 3:01 p.m. on 2/27/16, indicated the resident had been very anxious, had been transferred with a gait belt and was a maximum assistance of 1 for basic care with cueing. She had kept trying to use her right arm to pull herself up. The ace wrap was reapplied after she had taken it off, the sling was adjusted several times. Her upper bicep was swollen and discolored and ice applied.</p> <p>The next nursing entry was at 11:34 p.m. 2/27/16. The entry indicated at 9:30 p.m. the resident had been found lying on her stomach on the floor at the foot of her bed. She was assessed, complained of pain, an ambulance was called and she was transported to the hospital at 10:30 p.m.</p> <p>The hospital radiology report, 2/27/16, indicated "2 views of the right humerus were obtained and compared to a previous examination of the right shoulder performed on 2/26/16. There is a spiral displaced fracture of the midshaft of the right humerus. The displacement and angulation has increased compared to the previous study suggesting the fracture is unstable."</p>		<p>with subsequent falls, and the Facility care planned appropriately to minimize those risks. Despite these efforts, falls occurred including the fall with fracture. But these incidents did not result from Facility noncompliance. These incidents were unavoidable due to the residents' impulsivity and poor safety awareness. The Facility had appropriate interventions in place for fall management and fall safety for Resident B from her 12/15/2015 day of admit (attachment). When resident B fell on 2/27/2016 she was sent to the hospital with return on 3/12/2016 at which point Facility again implemented new interventions including 1:1 to establish a pattern of falls and behavior (attachment). The Facility complied with the cited regulation from the day of admit, and continues to follow the regulation, and the unavoidable accident should not be the basis for a citation. The facility maintains that it has and continues to remain compliant with the intent of F323 and respectfully requests that the citations of F323 be deleted.</p>		

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	<p>During an interview with the DON (Director of Nursing) on 3/3/16 at 3:00 p.m., she indicated staff were checking on the resident frequently, redirecting her, trying to get her involved in crafts. The DON indicated she expected frequent checking on a resident to be every 30 minutes. The record lacked documentation of the resident being monitored every 30 minutes.</p> <p>A current policy, dated 12/2011, titled "Falls Practice Guide" was provided by the DON on 3/2/16 at 3:45 p.m. The policy indicated "...Initial Evaluation To determine if a patient has factors that may place them at risk for falls...Initial Plan of Care...an initial plan of care is developed and individualized interventions are initiated....Interdisciplinary Care Planning...The interdisciplinary team designs the care plan to focus on all the patient's issues including those associated with fall prevention and fall risk management....Change In Condition Or Fall Occurrence...The care plan is revised as clinically indicated to meet the patient's current needs...."</p> <p>This federal tag relates to Complaint IN00194540.</p> <p>3.1-45(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155338	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING         _____		X3) DATE SURVEY COMPLETED 03/03/2016
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PRESTWICK			STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123		
(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	