

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
---	--

(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 the Investigation of Complaints IN00134355 and IN00134590.</p> <p>Complaint IN00134355 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F309.</p> <p>Complaint IN00134590 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 28 & 29, 2013</p> <p>Facility number: 001149 Provider number: 155618 AIM number: 200145500</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 45 SNF/NF: 32 Residential: 65 Total: 142</p> <p>Census Payor Type: Medicare: 13 Medicaid: 32 Other: 97</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: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>Total: 142</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on September 3, 2013.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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	
F000157 SS=D	<p>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).</p> <p>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 §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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to ensure the resident's physician was notified as well as a concerned family member in that when a totally dependent</p>	F000157	F-157Corrective action which will be accomplished for those residents found to have been affected by the deficient practice. Resident A presently remains at the facility.	09/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>resident sustained burns to the upper thigh area and the area began to blister at a later point after the initial occurrence, the nursing staff failed to immediately notify the resident's concerned family member, or the resident's physician for intervention which delayed treatment to the resident. This deficient practice affected 1 of 1 resident's reviewed for physician and family notification in a sample of 7. (Resident "A").</p> <p>Findings include:</p> <p>The record for resident "A" was reviewed on 08-28-13 at 12:40 p.m. Diagnoses included, but were not limited to, intercranial injury, acute respiratory failure, hypertension, quadriplegia, aphasia, and pain. These diagnoses remained current at the time of the record review.</p> <p>The clinical record, dated 07-15-13 at 15:40 (3:40 p.m.) indicated, "Lounge area congested due to children's choir presentation. Visitor inadvertently spilled coffee as trying to maneuver her [sic] through the crowd. Immediately removed resident from area. Removed clothes, washed resident upper thighs. Placed fresh clothing on the resident. Resident legs were reddened. Gave pain</p>		<p>He was provided care at the time of the event and the affected area is presently healed. His physician and Power of Attorney were notified immediately following the event. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents that suffer accidents with injuries or changes in condition. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff will receive in service education regarding reporting of changes in resident status to other nurses and aides. Licensed nurses will receive in service education on physician notification using INTERACT 3.0 Guidelines and documentation requirements of notifications. 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 in place? The ADNS or designee will conduct random reviews of accidents with injuries and resident changes in status notification 5 times weekly x 8 weeks. The outcomes will be reviewed by the facility's Quality Assessment and Assurance Committee weekly x 8 weeks and Recommendations for further corrective action will be discussed and implemented to sustain</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013	
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
(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>medication. Reported findings to physician and called [family member] and left message to return call."</p> <p>A review of the "Skin Worksheet," dated 07-15-13 (time not documented), indicated the resident sustained a "burn - reddened area." The "description" included "reddened upper thigh area noted to both thighs on top to medium thigh."</p> <p>The record indicated the resident received a shower on the afternoon of 07-15-13 by Certified Nurse Aide #11.</p> <p>Review of the investigative witness statements dated 07-16-13, at 9:00 a.m., Certified Nurse Aide #11 indicated, "Yes I worked yesterday [07-15-13] evening. Yes, [name of resident "A"] was my patient. I gave him a shower and didn't notice any blisters. It was just reddened between his legs."</p> <p>Investigative witness statement dated 07-16-13 at 8:45 a.m., Certified Nurse Aide #13 indicated, "Yes I worked yesterday evening. I didn't have [name of resident "A"] as a patient. The only interaction I had with the patient was when I helped [name of Certified Nurses aide #11] transferred him with a lift. No I didn't see any</p>		<p>compliance.Completion Date: 9/25/2013 IDRManor Care Health Services Summer Trace12999N Pennsylvania StreetCarmel, Indiana 46032-5415 INFORMAL DISPUTE RESOLUTION Cycle Date: Survey Date: Survey Type: Complaint Investigation: Manor Care of Summer Trace respectfully denies and disputes that it failed to comply with 42 C.F.R. § 483.10(b)(11) (F157) which requires a nursing facility to "immediately inform the resident; consult with the residents physician; and if known, notify the residents 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. 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 482.12(a)." The Statement of Deficiencies alleges that the facility "failed to ensure the resident's physician was notified as well as a concerned family member in that when a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>blisters or redness that I recall. I helped [name of Certified Nurses aide #11] get him dressed before transferring him with the lift and I didn't see anything when we dressed him either."</p> <p>Investigative witness statement dated 07-16-13 at 9:15 a.m., indicated Certified Nurses aide #12, " Yes I worked yesterday evening. No [name of resident "A"] was not my patient but when I helped [name of Certified Nurses Aide #11] get him back into bed using the lift, I noticed some small blisters on top of his leg so I reported this to the nurse."</p> <p>Continued review of the Nurse Progress notes indicated the following: "07-16-13 01:41 [1:41 a.m.] - At change of shift CNA [certified nurse aide] came to this writer and previous shift nurse and informed us of a skin alteration. The 2 [2:00 p.m.] - 10 [10:00 p.m.] CNA had informed the nurse, but she was unable to assess secondary to floor priorities at the time, which she did tell this writer. Then we proceeded to room to assess skin and observed blistering bilaterally on inner thighs, and red areas radiating down each inner thigh towards knee. Documented size and</p>		<p>totally dependent resident sustained burns to the upper thigh area and the area began to blister at a later point after the initial occurrence, the nursing staff failed to immediately notify the resident's concerned family member, or the resident's physician for intervention which delayed treatment to the resident." See Statement of Deficiencies, p. 3 of 12. The Statement of Deficiencies and F157 citation concern coffee accidentally spilled on Resident A by a visitor on July 15, 2013. The F157 citation should be deleted because, contrary to the allegation in the Statement of Deficiencies, the facility notified Resident A's physician and family immediately following the incident. The incident occurred at 1:00 p.m. on July 15, 2013. By 1:25 p.m. on July 15 both Resident A's physician and mother were notified of the incident by the facility. The facility again notified Resident A's physician and mother on the morning of July 16 after the facility identified the formation of blisters during the night. The facility complied with the cited regulation and the citation should be deleted. The facility presents the following evidence to demonstrate that it informed Resident A's physician and Power of Attorney timely following an injury. The facility denies that there was any delay in treating</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>description on skin alteration sheet. MD [medical doctor] informed in a.m." This Progress noted was documented by licensed nurse #14.</p> <p>A review of the "incident report," dated 07-15-16 at 10:23 p.m. indicated the following: "Was alerted by previous nurse that there was a skin alteration, and by 10 [10:00 p.m.] - 6 [6:00 a.m.], CNA. Went in to inspect skin and discovered bilateral blisters on inner thighs, with diffuse redness radiating down the inner thigh to mid section of thigh bilaterally. Noted on skin sheet." This incident report was completed by licensed nurse #14.</p> <p>Review of the "Skin Alteration Record," dated 07-16-13 indicated the resident had a "yellow blister" which measured 1.0 centimeters in length by 0.8 centimeters in width with no drainage, intact." This "record" was completed by licensed nurse #14.</p> <p>During an interview on 08-29-13 at 11:00 a.m., the Director of Nurses verified she interviewed the staff the following morning and indicated the resident was not found with the blisters until after he received a shower on the evening of 07-15-13.</p>		<p>Resident A and denies that as a result there was no worsening of the injury due to these alleged failures. The following evidence has been prepared and is submitted as a refutation of the cited deficiency, F157. The facility respectfully requests that the deficiency be deleted from public record for the reasons set forth below. IDR F157 Resident A is a 38 year old male with diagnosis including, but not limited to, intracranial injury, acute respiratory failure, hypertension, quadriplegia, aphasia, history of CVA, chronic pain and moderate cognitive impairment. He is non-verbal but can make some of his needs known through verbal expressions like moaning and through facial expressions. He is a long term resident that has resided at the facility since December 2011. He is a DNR and his mother is his Power of Attorney and actively involved in his care. Throughout Resident A's stay at the facility, he has received and continues to receive appropriate and necessary care and services. On 7/15/2013, at approximately 1:00 PM, Resident A was in the lounge observing a choir performance when a visitor, while maneuvering through the crowd, inadvertently spilled coffee onto Resident A's lap. Resident A was immediately removed from the lounge and taken to the nurse on duty for further assessment</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013	
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
(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 next morning his [family member] was notified and she wanted us to send him to the Emergency room."</p> <p>During an interview on 08-28-13 at 12:30 p.m., licensed nurse #5 indicated, "I came in to work on the following morning [07-16-13] and the night shift nurse told me about the blisters. She didn't report them to the doctor or the [family member] and she asked me to do it for her. I went and looked at him."</p> <p>Review of the facility policy on 08-29-13 at 9:05 a.m. and titled "Change in Condition: When to report to the MD [Medical Doctor] / NP [Nurse Practitioner] / PA [Physician Assistant]."</p> <p>"Immediate Notification [bold red type]: Any symptom or apparent discomfort that is: 1. Sudden [bold type and underscored] in onset. 2. A marked change [bold type and underscored] (i.e. more severe) in relation to usual symptoms and signs. 3. Unrelieved [bold type and underscored] by measures already prescribed."</p> <p>"Signs and Symptoms - Burns - Non - Immediate - Minor first degree burn in</p>		<p>and care. ASSESSMENT At approximately 1:00PM on 7/15/2013 Nurse Linda responded immediately to Resident A following the event of spilled hot liquids. Resident A was provided with an assessment of the injury and notifications to the both the Attending Physician and Resident A's family (mother) (ATTACHMENT 1). Upon this notification to the attending physician no new orders were received and the nurse was instructed to continue to monitor the resident. Resident A was assessed multiple times immediately following the event and at periods thereafter prior to his transfer to the ER for further evaluation the following morning (as per the family's request). (ATTACHMENT 2) · 7/15/2013 1:00PM-Immediately following the event-Resident assessed and provided skin care. VS: 118/72, 60, 18, 98.0. Pain assessed=0· 7/15/2013 2:35PM- Resident A assessed, no evidence of pain, VS: 103/68, 64, 18, 96.4· 7/15/2013 9:00PM- Resident A assessed, alert, no sign or symptoms of discomfort. · 7/16/2013 documented time 1:41AM-Resident A assessed at change of shift (approximately 11:00PM). Bilateral Blisters were noted. VS: 126/62, 62, 18, 98.3· 7/16/2013 10:30AM-To ER for evaluation-No noted facial grimacing. VS: 139/70, 72,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>past twenty four hours. Blisters - Immediate Secondary to any burn more than a minor one."</p> <p>This Federal tag relates to Complaint IN00134355.</p> <p>3.1-5(a)(2)</p>		<p>16, 96.9 It was noted that after the shower activities that occurred in the evening of 7/15/2013 that blisters were identified on the areas of the previously identified burn of Resident A. The Nurse, at the change of shift (approximately 11:00PM 7/15/2013), provided an comprehensive assessment of the blisters at that time as evidenced by documentation contained within the Nurses progress notes and Skin Alteration records. (ATTACHMENT 3). This assessment of Resident A yielded stable Vital Signs within normal and acceptable ranges. The facility alleges that it followed its INTERACT II guidelines for timely Physician notification of the developed blisters on Resident A's previously identified and reported burn area. (ATTACHMENT 4)Additional interviews were also obtained from Certified Nurse's Aide # 11, that during the shower on 7/15/2013, the resident did not appear to show any signs of pain or facial grimacing suggesting that the shower caused any discomfort to the resident at that time. (ATTACHMENT 5).Overall, Resident A received on-going monitoring and assessments of his status, and throughout the night there was no notable significant changes to his condition by way of Vital Sign changes or changes to his level</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
---	--

(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>of comfort from the development of the blisters until the morning, the time at which time the physician and family were notified. TIMELINESS and COMMUNICATION Upon notification of the initial event and injury at 1:00 PM on 7/15/2013 the Nurse on Duty provided immediate care to Resident A. Following her assessment and skin care at 1:20pm, a call was placed to Resident A's physician for notification and to obtain any further care and monitoring orders. Thereafter, at 1:25PM a call was placed to Residents Power of Attorney (mother) to notify her of the event and related injury and monitoring recommendations. Upon the identification of the blister formation at approximately 11:00PM 7/15/2013, the center alleges that it followed its INTERACT II notification guidelines and notified the Attending Physician the next morning along with Resident A's power of Attorney. Resident A sustained a minor burn injury on 7/15/2013 for which immediate notification to the Physician and Family was done. Resident A later developed blistering as a result of the aforementioned minor burn without any other significant change to his condition and per guidelines requires Routine Notification, which occurred the following morning. (ATTACHMENT 6.) According to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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 Statement of Deficiencies provided it states that: Notifications for Blisters is IMMEDIATE when they are secondary to any burn more than minor. Additionally, they state that Non-Immediate notification is done for any Minor burns in the past 24 hours. There is no evidence to suggest that the burn injury that Resident A sustained and the blisters that developed as a result of the burn injury was more than minor, it did not encompass a large body surface area (greater than 15%) nor were the blistered areas larger than 3 inches in diameter. Supporting documentation from the Emergency Room and the Wound Clinic also do not support that this burn injury was, at any time, considered Major. (ATTACHMENT 7) Also, per the Attending Physicians supplementary statement (ATTACHMENT 8), he suggests that he was not "surprised at all that there was progression of the burn to the development of blisters". The center alleges that Resident A did not develop any significant changes in his condition during the evening and night from 7/15/2013 until the morning of 7/16/2013 that necessitated a call to the Physician and/or family. Both the Physician and family were immediately made aware of the burn injury at the time of the event and per policy, routine</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>notification of Resident A's status was completed the following morning.</p> <p>SUMMATION ManorCare of Summer Trace maintains that it was and continues to remain in compliance with F157. The facility did provide appropriate and timely notifications to the physician and family of the initial burn injury. On 7/15/2013, after Resident A sustained a burn injury, he was immediately assessed by a Registered Nurse. His assessment was comprehensive in nature and vital signs along with a skin assessment of the injured area and pain evaluation were completed. He was assessed to be in stable condition from the development and identification of the blisters with stable Vital Signs and no evidence of pain or discomfort at that time until the time at which his physician and family were contacted again in the morning. Additionally, the facility followed it INTERACT II protocols for timely notification to the physician for the minor burn injury that was sustained. For the reasons set forth above, ManorCare of Summer Trace refutes and denies any and all allegations that it is not in substantial compliance with F157. The facility respectfully requests that the deficiency be deleted from public record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013	
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
(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			
F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 observation, record review and interview the facility failed to ensure the highest quality of care for a resident, in that when a totally dependent resident sustained burns to the upper thighs area, the nursing staff failed to communicate the condition of the resident to the nurse aides to prevent further injury to the area and failed to ensure follow-up assessment of the area was completed timely for intervention and treatment of the area resulting in the burn area advancing in the degree of injury for 1 of 1 resident's reviewed for burns in a sample of 7. (Resident "A").</p> <p>Findings include:</p> <p>The record for resident "A" was reviewed on 08-28-13 at 12:40 p.m. Diagnoses included, but were not limited to, intercranial injury, acute respiratory failure, hypertension, quadriplegia, aphasia, and pain. These diagnoses remained current at</p>	F000309	<p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice: Resident A presently remains at the facility. He was provided care at the time of the event and the affected area is presently healed. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents that develop significant changes in their condition What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff will receive in service education regarding reporting of</p>	09/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013	
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
(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 time of the record review.</p> <p>A review of the Minimum Data Set assessment, dated 05-39-13, indicated the resident had severe cognitive impairment, and was totally dependent upon the staff for activities of daily living.</p> <p>The clinical record, dated 07-15-13 at 15:40 [3:40 p.m.], "Lounge area congested due to children's choir presentation. Visitor inadvertently spilled coffee as trying to maneuver her [sic] through the crowd. Immediately removed resident from area. Removed clothes, washed resident upper thighs. Placed fresh clothing on the resident. Resident legs were reddened. Gave pain medication. Reported findings to physician and called [family member] and left message to return call."</p> <p>A review of the "Skin Worksheet," dated 07-15-13 (time not documented), indicated the resident sustained a "burn - reddened area." The "description" included "reddened upper thigh area noted to both thighs on top to medium thigh."</p> <p>The record indicated the resident received a shower on the afternoon of 07-15-13 by Certified Nurse Aide #11.</p>		<p>changes in resident status to other nurses and aides. · Licensed nurses will receive education on the use of the 24 hour report system and utilization for shift to shift reporting. · Licensed nurses will receive in service education to the process for assessment and reporting of significant changes in resident status to other nurses and aides. Residents that are identified to have a significant change in their condition will be reported to the Nurse Manager on Duty who will provide guidance as necessary for assessments, reporting and treatment of the significant changes in condition. 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 in place?· The ADNS or designee will conduct random reviews of resident changes in status evaluations and assessments 5 times weekly x 12 weeks. The outcomes will be reviewed by the facility's Quality Assessment and Assurance Committee weekly x 8 weeks and monthly x 3 months. Recommendations for further corrective action will be discussed and implemented to sustain compliance. · Completion Date: 9/25/2013IDR:Manor Care Health Services Summer Trace12999N Pennsylvania StreetCarmel, Indiana 46032-5415 INFORMAL</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>Review of the investigative witness statements dated 07-16-13, at 9:00 a.m., Certified Nurse Aide #11 indicated, "Yes I worked yesterday [07-15-13] evening. Yes, [name of resident "A"] was my patient. I gave him a shower and didn't notice any blisters. It was just reddened between his legs."</p> <p>Investigative witness statement dated 07-16-13 at 8:45 a.m., Certified Nurse Aide #13 indicated, "Yes I worked yesterday evening. I didn't have [name of resident "A"] as a patient. The only interaction I had with the patient was when I helped [name of Certified Nurses aide #11] transferred him with a lift. No I didn't see any blisters or redness that I recall. I helped [name of Certified Nurses aide #11] get him dressed before transferring him with the lift and I didn't see anything when we dressed him either."</p> <p>Investigative witness statement dated 07-16-13 at 9:15 a.m., indicated Certified Nurses aide #12, "Yes I worked yesterday evening. No [name of resident "A"] was not my patient but when I helped [name of Certified Nurses Aide #11] get him back into bed using the lift, I noticed some</p>		<p>DISPUTE RESOLUTION Cycle Date: Survey Date: Survey Type: Complaint Investigation: Manor Care of Summer Trace respectfully denies and disputes that it failed to comply with 42 C.F.R. §483.25 (F309) which provides that a facility "must provide the necessary care and services to attain or maintain each resident's highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and care plan." The Statement of Deficiencies alleges that facility "failed to ensure the highest quality of care for a resident, in that when a totally dependent resident sustained burns to the upperhighs area, the nursing staff failed to communicate the condition of the resident to thenurse aides to prevent further injury to the area and failed to ensure follow-up assessment of the area was completed timely for intervention and treatment of the area resulting in the burn area advancing in the degree of injury . . ." See Statement of Deficiencies, p. 7 of 12. The Statement of Deficiencies and F309 citation concern coffee accidentally spilled on Resident A by a visitor on July 15, 2013. The F309 citation should be deleted because the facility immediately assessed Resident A at the time of the incident and continued to assess Resident A throughout</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>small blisters on top of his leg so I reported this to the nurse."</p> <p>Continued review of the Nurse Progress notes indicated the following: "07-16-13 01:41 [1:41 a.m.] - At change of shift CNA [certified nurse aide] came to this writer and previous shift nurse and informed us of a skin alteration. The 2 [2:00 p.m.] - 10 [10:00 p.m.] CNA had informed the nurse, but she was unable to assess secondary to floor priorities at the time, which she did tell this writer. Then we proceeded to room to assess skin and observed blistering bilaterally on inner thighs, and red areas radiating down each inner thigh towards knee. Documented size and description on skin alteration sheet. MD [medical doctor] informed in a.m."</p> <p>A review of the "incident report," dated 07-15-16 at 10:23 p.m. indicated the following: "Was alerted by previous nurse that there was a skin alteration, and by 10 [10:00 p.m.] - 6 [6:00 a.m.] CNA. Went in to inspect skin and discovered bilateral blisters on inner thighs, with diffuse redness radiating down the inner thigh to mid section of thigh bilaterally. Noted on skin sheet."</p>		<p>July 15 and early on July 16 until he was sent to the emergency room for evaluation at the request of Resident A's mother and pursuant to an order from his physician. Contrary to the Statement of Deficiencies, the facility performed immediate and follow-up assessments of Resident A, along with communication with his physician and family. Because the citation is not supported by the facts, the citation should be deleted. In furtherance of this request for informal dispute resolution, the facility presents the following evidence to demonstrate that it performed a timely assessment of Resident A following an accidental hot liquid spill and provided immediate Physician and family communication for resident A. There was no delay in treating Resident A and no worsening of Resident A's injury as implied by the 2567.. The following evidence has been prepared and is submitted as a refutation of the cited deficiency, F309. The facility respectfully requests that the deficiency be reduced in severity or deleted from public record for the reasons set forth below. Resident A Resident A is a 38 year old male with diagnosis including, but not limited to, intracranial injury, acute respiratory failure, hypertension, quadriplegia, aphasia, history of CVA, chronic pain and moderate cognitive</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>Review of the "Skin Alteration Record," dated 07-16-13 indicated the resident had a "yellow blister" which measured 1.0 centimeters in length by 0.8 centimeters in width with no drainage, intact."</p> <p>During an interview on 08-29-13 at 11:00 a.m., the Director of Nurses verified she interviewed the staff the following morning and indicated the resident was not found with the blisters until after he received a shower on the evening of 07-15-13. The next morning his [family member] was notified and she wanted us to send him to the Emergency room. We had already setup an appointment at the Wound clinic but she said 'no, I want him to go to the ER [Emergency Room].' When we first told the doctor about the incident and there were no blisters at that time, he told us to monitor the areas."</p> <p>A review of the Emergency Room documentation, dated 07-16-13 indicated, "Patient has burns to bilateral upper thighs near groin from scald injury yesterday. Patient's [family member] saw burns today and didn't want patient to wait for wound care to see patient on Friday [07-19-13]. Patient has bilateral</p>		<p>impairment. He is non-verbal but can make some of his needs known through verbal expressions like moaning and through facial expressions. He is a long term resident that has resided at the facility since December 2011. He is a DNR and his mother is his Power of Attorney and actively involved in his care. Throughout Resident A's stay at the facility, he has received and continues to receive appropriate and necessary care and services. On 7/15/2013, at approximately 1:00 PM, Resident A was in the lounge observing a choir performance when a visitor, while maneuvering through the crowd, inadvertently spilled coffee onto Resident A's lap. Resident A was immediately removed from the lounge and taken to the nurse on duty for further assessment and care. ASSESSMENT Nurse Linda responded immediately to assess Resident A. Her assessment findings are recorded in the electronic Progress Note (ATTACHMENT 1) the Incident Report (ATTACHMENT 2). Both of these reports are dated 7/15/2013. In the progress note, Nurse Linda documents that she provided an assessment and skin care for Resident A. Further clarification statements provided by Nurse Linda on 9/12/13 to detail the care she provided state that the resident had "his clothing removed and the area was cleansed with cool water. It was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>blisters intact with some mild redness below burns down inner thighs."</p> <p>During an interview on 08-28-13 at approximately 8:45 a.m., with Registered Nurse #3 in attendance, the resident was lying in bed. The nurse indicated the resident had recently sustained burns to the upper thighs due to a coffee spill from a visitor. An observation at this time, the Registered Nurse explained to the resident the need to observe the affected area of his thighs. The nurse pulled back the sheet. The resident had an incontinent brief on. A darkened area, different that the resident's skin color, spanned from the upper thigh down towards the resident's knees bilaterally. The Registered Nurse verified this discoloration was from the previously blistered skin resulting from the coffee spill on 07-15-13.</p> <p>During an interview on 08-28-13 at 12:30 p.m., licensed nurse #5 indicated, "I came in to work on the following morning [07-16-13] and the night shift nurse told me about the blisters. She didn't report them to the doctor or the [family member] and she asked me to do it for her. I went and looked at him. I also asked [name of maintenance staff] to check the water</p>		<p>padded dry with dry sterile gauze and left open to air." (ATTACHMENT 3). The Statement of Deficiencies suggest that the aftercare provided to Resident A was insufficient, however the clarification statement provided by Nurse Linda supports that appropriate care of Resident A's burn injury was provided immediately following the event. Also, supporting literature suggests that a treatment option for burns is to cleanse the area gently with soap and water. If the skin of the burned area is unbroken, it should be left exposed to the air to promote healing. (ATTACHMENT 4)Resident A was provided with an assessment of the injury and notifications to the both the Attending Physician and Resident A's family (mother). Upon this notification to the attending physician no new orders were received and the nurse was instructed to continue to monitor the resident. Resident A was assessed multiple times immediately following the event and at periods thereafter prior to his transfer to the ER for further evaluation the following morning. (ATTACHMENT 5) · 7/15/2013 1:00PM-Immediately following the event-Resident assessed and provided skin care. VS: 118/72, 60, 18, 98.0. Pain assessed=0· 7/15/2013 2:35PM- Resident A assessed,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013	
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032			
(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>temperatures. He did and told me they were within range. According to what is being said the he got his shower and was put back to bed. The day shift nurse didn't remember him even being out of the bed the day the burn occurred."</p> <p>The maintenance records were reviewed and the hot water temperatures taken in the "second floor tub room" were documented at 110.2 degrees. The hot water temperatures documented on 07-16-13 indicated the "second floor tub room," were documented at 118 degrees.</p> <p>A review of professional material resource on 08-28-13 at 4:30 p.m. indicated "Med-LinePlus - minor burn." "Run cool water over area of burn. Cover the burn with a sterile bandage."</p> <p>Review of the "Lippincott Manual of Nursing Practice Handbook," on 08-28-13 at 4:45 p.m. indicated, "Burns are a form of traumatic injury caused by thermal, electrical, chemical or radioactive agents. Most burn related accidents occur at home: others occur at work. Nursing Interventions - monitoring - check vital signs every 15 minutes until</p>		<p>no evidence of pain, VS: 103/68, 64, 18, 96.4· 7/15/2013 9:00PM- Resident A assessed, alert, no sign or symptoms of discomfort.· 7/16/2013 documented time 1:41AM-Resident A assessed at change of shift (approximately 11:00PM). Bilateral Blisters were noted. VS: 126/62, 62, 18, 98.3· 7/16/2013 10:30AM- To ER for evaluation-No noted facial grimacing. VS: 139/70, 72, 16, 96.9 Lippincott Manual of Nursing Practice, 10th edition, was reviewed and there was no evidence to support that minor burn injuries required Vital Sign assessment every 15 minutes until stable. Additionally, Vital signs obtained immediately following the event and thereafter do not suggest abnormalities or significant variations from the normal for Resident A. The facilities INTERACT II guidelines provided appropriate guidance for the physician notification of the injury of a minor burn. (ATTACHMENT 6) Resident A was scheduled for his routine shower that evening, and this was provided by Certified Nurse's Aide #11. The Statement of Deficiency suggests that the injury that Resident A had previously sustained was worsened by the shower event. However, in referencing Lippincott Manual of Nursing Practice, 10th edition, part of routine care for a burn is to cleanse the area initially and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
---	--

(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>stabilized, then as indicated by condition, monitor temperature, monitor wounds for infection."</p> <p>During a telephone interview on 08-29-13 at 10:15 a.m., Certified Nurses aide #11 indicated he was suppose to be at work at 2:00 p.m., but arrived late "3:00 p.m. When I got there [name of resident] was in bed and they told me to give him a shower. I took him to the shower room. When I was drying him I saw it was red [emphatic] but I didn't tell anyone. No one told me anything and that is what I told them when they interviewed me about it the next day. I should have reported the redness to the nurse - but it slipped my mind. Another CNA [Certified Nurses aide] helped me put him back to bed after the shower. That's when she saw the blisters."</p> <p>The clinical record lacked documentation of ongoing monitoring of the burned area on 07-15-13, the use of a sterile dressing over the affected area, or communication amongst nursing staff of the incident which could have alerted the Certified Nurses aide of the recent burned area, and whether the resident should or should not have received a shower.</p>		<p>daily, and this may be done in the bathtub or shower. Also, statements were obtained from Resident A's attending physician to support that, in his opinion, the shower event did not cause any worsening of the initial burn injury, and in fact may have been therapeutic for Resident A. (ATTACHMENT 7) It is also suggested that the water temperatures within the shower room played a factor in the worsening of the injury. It is documented that the water temperatures obtained by maintenance on the day after the event showed the shower room water temperature to be at 118 degrees Fahrenheit. The recorded shower temperatures on the day of the event indicate that the 2nd floor tub room water temperature was recorded at 109.1 Degrees Fahrenheit and on the day prior to the event it was recorded at 108.4 Degrees Fahrenheit (ATTACHMENT 8). Evidence within Lippincott Manual of Nursing Practice, 10th Edition states that full thickness burn injuries occur from prolonged exposure of 5 minutes or greater at temperatures of 120 degrees Fahrenheit or greater, and this temperature exceeds the shower room water temperatures for both days provided. Additional interviews were obtained from Certified Nurse's Aide # 11, that during the shower on 7/15/2013, the resident did not appear to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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	
	This Federal tag relates to Complaint IN00134355. 3.1-37(a)		show any signs of pain or facial grimacing suggesting that the shower caused any discomfort to the resident at that time. (ATTACHMENT 9). TIMELINESS and COMMUNICATION Upon notification of the initial event and injury at 1:00 PM on 7/15/2013 the Nurse on Duty provided immediate care to Resident A. Following her assessment and skin care at 1:20pm, a call was placed to Resident A's physician for notification and to obtain nay further care and treatment orders. Thereafter, at 1:25PM a call was placed to Residents Power of Attorney (mother) to notify her of the event and related injury and treatment orders. Upon the identification of the blister formation, the center alleges that it followed its INTERACT II notification guidelines and notified the Attending Physician the next morning along with Resident A's power of Attorney. Resident A sustained a minor burn injury on 7/15/2013 for which immediate notification to the Physician and Family was done. Resident A later developed blistering as a result of the aforementioned minor burn without any other significant change to his condition and per guidelines requires Routine Notification, which occurred the following morning. (ATTACHMENT 10.) There is no evidence to suggest that the burn injury was more than minor, it did not encompass a large body		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>surface area (greater than 15%) nor were the blistered areas larger than 3 inches in diameter. Supporting documentation from the Emergency Room and the Wound Clinic also do not support that this burn injury was considered Major. (ATTACHMENT 11) The Statement of Deficiencies suggests that a lack of communication between the Nurse and Nurses' Aides resulted in advancing in the degree of injury for Resident A. There were no orders in place after the event to hold shower or bathing activities for Resident A and the Statement provided by Resident A's attending Physician supports that the shower event did not play a contributing factor in the development of blisters and may have been beneficial for Resident A. (ATTACHMENT 7). Although statements mentioned in the Statement of Deficiencies suggest that there was a lack of Nurse to Nurse's Aide communication, there is no evidence to support that this lack of communication resulted in further harm to Resident A. SUMMATION Manor Care of Summer Trace maintains that it was and continues to remain in compliance with F309. The facility did provide necessary care and services to Resident A to attain or maintain his well-being in accordance with his comprehensive assessment and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032		
(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>plan of care. On 7/15/2013, after Resident A sustained a burn injury, he was immediately assessed by a Registered Nurse. His assessment was comprehensive in nature and vital signs along with a skin assessment of the injured area and pain evaluation were completed. He was assessed to be in stable condition with stable Vital Signs and no evidence of pain or discomfort at that time. He was supervised, attended to and made comfortable while his attending physician and family were informed of the incident. The facility followed the instructions provided to them by the Physician in the aftercare of Resident A. The suggestion that the accidental injury sustained by Resident A was made worse by the shower event is presumptive and contradicted in the Attending Physicians statement. Additionally, the facility followed it INTERACT II protocols for timely notification to the physician for the minor burn injury sustained. For the reasons set forth above, Manor Care of Summer Trace refutes and denies any and all allegations that it is not in substantial compliance with F309. The facility respectfully requests that the deficiency be reduced in severity or deleted from public record.</p>		