

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaints IN00159636, IN00159676, IN00160017, and IN00160549.</p> <p>Complaint IN00159636 - Unsubstantiated due to lack of evidence</p> <p>Complaint IN00159676 - Unsubstantiated due to lack of evidence</p> <p>Complaint IN00160017 - Substantiated. Federal/State findings related to the allegations are cited at F157, F279, F312, F314, F325, and F514.</p> <p>Complaint IN00160549 - Substantiated. Federal/State findings related to the allegations are cited at F157, F279, F312, F314, F325, and F514.</p> <p>Survey dates: December 2, 3, 4, and 8, 2014</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 120</p>	F000000	<p>The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</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:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000157 SS=D	<p>SNF: 33 Total: 153</p> <p>Census payor type: Medicare: 23 Medicaid: 95 Other: 35 Total: 153</p> <p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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 an on call Nurse Practitioner was aware of a resident's prior fall when the resident experienced a decline in condition and failed to ensure a resident's family continued to be informed of a decline in the resident's physical condition with the possible need for hospital transfer for 1 of 3 residents reviewed for physician and family notification in a sample of 6. (Resident #E)</p> <p>Findings include:</p> <p>The clinical record for Resident #E was reviewed on 12/3/14 at 1:50 p.m. Diagnoses for the resident included, but</p>	F000157	<p><b>F157 Notify of Changes (Injury/Decline/Room, Etc.)</b></p> <p>It is the practice of the center to comply with F157, Notification of Change.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident E : No longer resides at the facility</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>Residents with a change in condition</p>	01/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>were not limited to, debility, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>An admission MDS assessment, dated 10/30/14, indicated Resident #E required the assistance of the staff for all activities of daily living.</p> <p>A post fall assessment, dated 12/1/14 at 12:40 p.m., indicated the resident had been found on the floor of her room and had fallen from her bed on 11/30/14 at 7:30 a.m. The clinical record indicated vital signs and neurocheck assessments were completed in regards to the resident's fall.</p> <p>A nursing note entry, dated 12/2/14 at 12:03 a.m., indicated "resident not eating and or drinking, resident capillary refill greater than 10 seconds, noted eyes sunken, resident vitals 104/70, pulse 49, 02 [oxygen saturation] 97%, temp 98.7, respirations 18, called NP [Nurse Practitioner] on call, spoke to about running some labs and maybe starting a IV for fluids due to the fact that resident is not eating and or drinking, for both shift with barely any output. NP wants to hold on fluids and draw a STAT [immediate] BMP [basic metabolic profile], lab does not due STAT BMP after 2 pm notified that patient can have it</p>		<p>have the potential to be affected by the alleged deficient practice.</p> <p>The clinical records of any resident who has experienced a change in condition within the past 7 days have been reviewed to ensure they include documentation of the resident's situation or condition, physician notification, and family notification. Those resident records noted to be incomplete will be updated with a current assessment and updates will be provided to the physician and family as applicable.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>ADNS or designees will review 24 hour progress notes daily, 5 days a week, to review and identify residents who are exhibiting a change in condition. Based on identification, residents will be placed on alert charting for improved documentation and communication of the resident's condition and facilitate a more comprehensive review when physicians and families are notified.</p> <p>Licensed Nursing staff has been re-educated on Interact III, which focuses on the identification of a new condition or situation, capturing relevant background information, documentation of a resident's</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>early in AM, NP is aware, patient has increased weakness noted, not able to verbalize. Resident very confused more than normal...."</p> <p>The nursing note lacked any information related to the resident's family having been notified of the resident's change in condition as noted. The nursing note entry lacked any information related to whether the NP was aware of the resident having fallen on 11/30/14.</p> <p>The DON was interviewed on 12/4/14 at 10:30 a.m. Additional information was requested related to family notification of the decline in the resident's condition. The DON provided a copy of the telephone order written for the STAT BMP as noted. The order indicated the physician was contacted and the order obtained on 12/1/14 at 10 p.m. The DON indicated this information was not charted until 12:03 a.m. on 12/2/14. A notation on the telephone order indicated the family was contacted in regards to the order for the STAT BMP. The notation did not indicate what information was provided or what family member the nurse contacted.</p> <p>A nursing note entry, dated 12/2/14 at 6:35 a.m., indicated "Resident's eyes continue to be fixed. Slight noises made.</p>		<p>assessment in response to the change in condition, reporting findings to physicians and following through with recommendations or orders received. Education included the notification of family or responsible parties with the findings and plan of care.</p> <p>The Director of Care Delivery or designee will conduct chart reviews for a total of 10 residents per week to ensure Nurses are meeting the documentation and notification requirements and record findings on the QAA monitoring tool. Corrective action will be taken for any identified concerns in which the expectations were not achieved as outlined above.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process</p> <p><b>By what date the systemic changes will be completed?</b> January 7, 2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Not able to register BP. O2 sats at 92% on room air. Pulse-47. Resident turned every 2 hours. Resident not able to take medication. NP aware. Resident is to have a stat BMP drawn this morning. Oral care done."</p> <p>The nursing note on 12/2/14 at 6:35 a.m. lacked any information related to the resident's family having been contacted in regards to the resident's continued decline, lack of a blood pressure, eyes being fixed, and/or the families wishes in regards to possible hospital transfer.</p> <p>The next nursing note was dated 12/2/14 at 7:53 a.m. and indicated "Attempted to reach MD [Medical Doctor] recording reached, attempted to reach NP, left message stating resident's decline, fixed eyes. Message left with first contact. Spoke with second contact and requested to be sent to ER [emergency room]."</p> <p>The DON and LPN #6 (the Unit Manager for Resident #E's unit) were interviewed on 12/4/14 at 10:30 a.m. Additional information was requested related to the lack of family notification of the resident's continued decline on 12/2/14 at 6:35 a.m. and if the NP was aware of the resident's fall on 11/30/14 prior to the decline in condition.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000279 SS=D	<p>LPN #6 was interviewed on 12/4/14 at 1:45 p.m. She indicated she had talked with LPN #7 (the nurse on duty on 12/2/14 at 6:35 a.m.). She indicated LPN #7 stated she did talk with the NP at that time and informed her of the resident's continued decline, but the conversation was "rushed" and she could not remember if the NP was aware of the resident's fall on 11/30/14. LPN #7 indicated she had not called the family at that time since they had already been called on 12/1/14 when the order for the stat BMP had been received even though the resident's condition had continued to decline.</p> <p>This federal tag relates to Complaint IN00160549 and IN00160017.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive plan of care with measurable objectives and timetables was developed for a resident with multiple open wounds for 1 of 3 residents reviewed for comprehensive wound health care plans in a sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 12/3/14 at 12:30 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus with renal manifestations, end stage renal disease, gastric esophageal reflux disease, fractured femur, and depressive disorder.</p> <p>The clinical record indicated the resident had been admitted to the hospital from the dialysis center on 12/1/14 due to bleeding from the dialysis graft site. The clinical record indicated the resident had</p>	F000279	<p><b>F279 Develop Comprehensive Care Plans</b></p> <p>It is the practice of this center to comply with the requirements of F279 – Developing Comprehensive Care Plans</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident B: No longer resides at the facility</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>Residents with Pressure Ulcers/skin alterations have the potential to be affected by this alleged deficient practice.</p> <p>·Residents with Pressure Ulcers/Skin Alterations have been reviewed to ensure their clinical</p>	01/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>multiple pressure and/or vascular ulcers at the time of her admission to the hospital.</p> <p>The clinical record contained a health care plan, last reviewed on 10/6/14, which indicated the resident was "at risk for alteration in skin integrity related to normal disease progression with unavoidable decline, incontinence, impaired mobility, diabetes, edema, end stage renal disease, use of immobilizer/splint due to femur fracture". Interventions for wound prevention were listed. The clinical record lacked any health care plan in place for treatment of actual wounds and or pressure ulcers.</p> <p>The DON was interviewed regarding the various wounds on 12/8/14 at 12:25 p.m. The following wound information was indicated:</p> <p>The resident had a wound on her coccyx, 2 areas on the front of her right lower leg, one area on the back of her right lower leg, one area on her right heel, and one area on the top of her right foot. Some were felt to be pressure areas and some were vascular in nature. The treatment dates of the areas went back as far as 9/27/14 for some of the areas and all were being measured with various wound treatments in place.</p>		<p>record and comprehensive care plan reflect assessments and care needs.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>The Director of Care Delivery or designee will complete an Initial audit of all residents with Pressure Ulcers/Skin alterations to ensure comprehensive care plans are developed and reflect the current status of the wounds. Newly identified areas will be updated on the audit tool weekly to ensure a comprehensive care plan is developed. Corrective action will be taken for any identified concern to ensure compliance is sustained.</p> <p>Licensed nurses have been provided education on development of health care plans.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000312 SS=E	<p>The DON indicated she was unable to provide any comprehensive health care plan having been developed in regards to the resident's multiple wounds which included measurable objectives and timetables for care.</p> <p>This federal tag relates to Complaint IN00160549 and IN00160017.</p> <p>3.1-35(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nail care was provided to 3 of 4 residents reviewed for assistance with nail care in a sample of 6. (Resident #D, #F, and #G)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #D was reviewed on 12/3/14 at 1:40 p.m. Diagnoses for the resident included, but</p>	F000312	<p>QA&amp;A process</p> <p><b>By what date the systemic changes will be completed?</b> January 7, 2015</p> <p><b>F312 ADL Care Provided for Dependent Resident</b></p> <p>It is the center's practice to comply with the requirements of F312, ADL Care Provided for Dependent Residents</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident D, Resident F, and Resident</p>	01/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>were not limited to, intracerebral hemorrhage with hemiplegia, diabetes mellitus, and muscle weakness.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 9/30/14, indicated Resident #D was severely cognitively impaired and required the assistance of the staff for all activities of daily living.</p> <p>A health care plan problem, reviewed on 10/15/14, indicated Resident #D required extensive assistance with all activities of daily living due to physical limitations and right sided hemiplegia. One of the approaches for this problem was for staff to "assist with daily hygiene, grooming, dressing, and oral care as needed".</p> <p>During an observation conducted with LPN #12 on 12/3/14 at 3:55 p.m., Resident #D was resting in bed. Her fingernails were very long and jagged, with the left hand being worse than the right.</p> <p>LPN #12 was interviewed on 12/3/14 at 3:55 p.m. She indicated the resident's fingernails were too long and she would see that they were trimmed.</p> <p>Resident #D was interviewed on 12/3/14 at 3:55 p.m. When asked if she would</p>		<p>G's nails were observed and residents were provided assistance with nail care; Clinical records were reviewed and revised to include resident's need for assistance with ADL care, as well as any resident specific preferences as applicable.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>Residents that require assistance with nail care have the potential to be affected by this alleged deficient practice.</p> <ul style="list-style-type: none"> <li>- Inspection was conducted on resident nails. Those identified who would benefit from nail care or those expressing interest were provided the necessary nail care.</li> <li>- The clinical records for all residents that require assistance with nail care have been reviewed and revised as needed to reflect the need for assistance with hygiene, as well as any personal preferences if applicable.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>New admissions or those with any significant change in ADL ability will have their care plans reviewed</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>like her fingernails trimmed, she indicated "yes" she would like to have them trimmed.</p> <p>2. The clinical record for Resident #E was reviewed on 12/4/14 at 2:30 p.m. Diagnoses for the resident included, but were not limited to, dementia without behavioral disturbances and muscle weakness.</p> <p>An annual MDS assessment, dated 11/11/14, indicated Resident #E was severely cognitively impaired and required the assistance of the staff for all activities of daily living.</p> <p>A health care plan problem, reviewed on 11/30/14, indicated Resident #E had a self care deficit as evidenced by decreased mobility related to physical limitations. One of the approaches for this problem was for staff to "assist with daily hygiene, grooming, dressing, oral care, and eating as needed".</p> <p>During an observation conducted with LPN #8 on 12/3/14 at 4 p.m., Resident #E was resting in bed. Her fingernails were very long and jagged. Old fingernail polish was noted on the center of the nails which was worn and flaking off. Some dark debris was noted in the grooves of some of the nails.</p>		<p>and modified as needed to identify their individual nail care needs.</p> <p>Nursing staff have been re-educated on the Nail Care Guidelines.</p> <p>Director of Care Delivery or Designee will conduct 10 observations per week of residents that required assistance with nail care and record findings on QAA audit tool. Any identified concerns will be corrected immediately to sustain compliance.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process.</p> <p><b>By what date the systemic changes will be completed?</b> January 7, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>LPN #8 was interviewed on 12/3/14 at 4 p.m. She indicated the resident's fingernails were too long and she would see that they were trimmed.</p> <p>Resident #E was interviewed on 12/3/14 at 4 p.m. When asked if she would like her fingernails trimmed, she indicated "yes, they are too long and get caught on my clothes".</p> <p>3. The clinical record for Resident #G was reviewed on 12/4/14 at 2:40 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease and hypertension.</p> <p>A significant change MDS assessment, dated 10/28/14, indicated Resident #G was severely cognitively impaired and required the assistance of the staff for all activities of daily living.</p> <p>During an observation on 12/3/14 at 4 p.m., Resident #G was resting in her room. Her fingernails were long and irregular in shape. When queried if she would like to have her fingernails trimmed, she indicated "yes, but I can't afford to pay for it."</p> <p>During an observation on 12/3/14 at 4:05 p.m., LPN #9 indicated the resident's</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000314 SS=G	<p>fingernails did need to be trimmed. She told the resident it would be done free of charge and the resident was happy with that information.</p> <p>4. Review of the current facility policy, revised 1/2014, titled "Nail Care", provided by the DON on 12/8/14 at 9:40 a.m., included, but was not limited to, the following:</p> <p>"Purpose: To provide for personal hygiene needs and prevent infection.</p> <p>...Procedure:...</p> <p>Suggested documentation:</p> <p>Completion of procedure Unusual observations and/or complaints and subsequent interventions including communications with physician."</p> <p>This federal tag relates to Complaint IN00160549 and IN00160017.</p> <p>3.1-38(a)(3)(E)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure treatments to pressure wounds were maintained and/or completed as ordered to promote healing of the wounds and prevent contamination from fecal matter resulting in a worsening of the pressure ulcers and increased potential for infection for 1 of 3 residents reviewed for pressure ulcer treatment in a sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>During an observation with LPN #4 on 12/8/14 at 8:45 a.m., Resident #D was resting in bed. The dressing on her left heel was checked by LPN #4. The dressing was dated 12/6/14 and contained the initials of [LPN #10]. The dressing change was completed by LPN #3 and LPN #4. The old dressing, dated 12/6/14, was removed, the wound cleansed, and the new treatment and dressing applied as ordered. LPN #3 dated and initialed the new dressing on the left heel.</p>	F000314	<p><b>F 314 Treatment/Services to Prevent/Heal Pressure Sores</b></p> <p>It is the center's practice to comply with the requirements of F314 – Treatment/Services to Prevent/Heal Pressure Ulcers</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident D: Head to toe assessment was completed to validate current skin condition. Findings were communicated to physician and treatment orders validated. Family notified of findings and plan of care. Care plan reviewed to ensure that risks were captured and plan of care contained approaches which promoted healing through treatment and prevention. Treatment record reviewed to validate all existing and new orders were consistent with MD orders.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</b></p>	01/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The area on the left heel was measured during the completion of the treatment. LPN #3 indicated the wound measured 3 cm by 3 cm. This indicated a worsening of the wound since it was measured on 12/4/14.</p> <p>The wound to the resident's right lower buttock was also observed on 12/8/14 at 9:10 a.m. LPN #3 and LPN #4 removed the resident's incontinent brief so the wound could be observed. No dressing was in place on the resident's wound on the right lower buttock. The wound was open to the brief and a smear of fecal matter was noted in the brief and in contact with the open wound. The brief was checked and no loose dressing was present in the brief.</p> <p>The wound on the resident's right lower buttock was measured during the observation above. The wound measured 5.5 cm by 3 cm. The center of the wound was gray and was indicated by LPN #3 to be "slough". The wound was cleansed and the treatment completed as ordered on 12/4/14. The new dressing was dated 12/8/14 and LPN #3 initialed the dressing. A smaller excoriated area was noted above the larger wound. It measured 2.5 by 2 cm. Both areas were covered by the dressing.</p>		<p><b>actions will be taken;</b></p> <p>Residents with pressure ulcers have the potential to be affected by the alleged deficiency.</p> <ul style="list-style-type: none"> <li>· A full skin inspection was completed on patients with pressure ulcers to ensure that the presence of pressure wounds had been accurately recorded.</li> <li>· Treatment orders were reviewed with physician; any new orders were carried out as applicable.</li> <li>· Clinical records were reviewed to validate that the appropriate assessments and care plans had been completed and were accurate based on inspection; any discrepancies were corrected.</li> <li>· Validations completed to ensure that family/representatives had been updated with any change in condition or plan of care.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</b></p> <p>ADNS or designee will review progress notes daily during morning meeting and present any resident with new or declining wounds to the IDT. Chart reviews will be completed to validate compliance has been sustained. Any identified concerns will be corrected immediately.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>LPN #3 and LPN #4 were interviewed on 12/8/14 at 9:30 a.m. They indicated no CNA had notified them that the dressing was not in place on the wound when peri care was last given. They indicated they were unaware the wound was undressed until the observation made at this time.</p> <p>The clinical record for Resident #D was reviewed on 12/3/14 at 1:40 p.m. Diagnoses for the resident included, but were not limited to, intracerebral hemorrhage with hemiplegia, diabetes mellitus, and muscle weakness. The clinical record indicated the resident received hospice services.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 9/30/14, indicated Resident #D was severely cognitively impaired and required the assistance of the staff for all activities of daily living.</p> <p>A health care plan problem, dated 11/14/14, indicated Resident #D had a unstageable ulcer to the right buttock related to diabetes, impaired mobility, incontinence, and friction. One of the approaches for this problem was for the staff to administer treatment per the physician's orders.</p> <p>A skin risk assessment, dated 11/13/14,</p>		<p>Licensed Nursing staff has been re-education on the Skin Management Guidelines to include completion of treatments per physician's order required documentation that treatment was completed.</p> <p>Certified Nursing Assistants will be educated on Skin Management Guidelines to include notification to the Nurse if pressure ulcer is noted without a treatment or dressing intact.</p> <p>The Director of Care Delivery or designee will conduct 10 observations per week of residents with pressure ulcers to ensure treatments are in place and documented per physician's order.</p> <p>Director of Care Delivery or designee will interview 10 Certified Nursing Assistants per week to ensure they are aware of the process of notifying the Nurse when there is an open area or treatment not in place.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</b></p> <p>Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated Resident #D had a score of 13. This indicated the resident was at moderate risk for development of pressure ulcers.</p> <p>A Nurse Practitioner (NP) note, dated 12/4/14, indicated Resident #D had a pressure ulcer on her left heel. The note indicated the area measured 2.0 centimeters (cm) by 2.0 cm. The note indicated the area was "unstageable". The treatment order for this area, dated 12/4/14, indicated the staff were to apply a silvasorb dressing (a medicated dressing) to the left heel daily and cover with medipore (a dressing to help protect the wound and keep the silvasorb dressing in place). The NP note also indicated the resident had an open area on her right hip. The note indicated the area measured 4.0 cm by 4.0 cm. A treatment order, dated 12/4/14, indicated the previous treatment was being discontinued and new order was written for Normagel [a spongy gel dressing] to the hip wound daily covered by a Medipore dressing.</p> <p>The December, 2014 Treatment Administration Record (TAR) for Resident #D indicated the treatment on the left heel was initiated on 12/4/14 as ordered by the physician. The TAR indicated the treatment was completed by</p>		<p>Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process.</p> <p><b>By what date the systemic changes will be completed?</b> January 7, 2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>[initials of LPN #10) on 12/6/14 which is consistent with the date and initials on the dressing observed on 12/8/14. The December, 2014 TAR also indicated the dressing was changed on 12/7/14 by [initials of RN #11]. This date and initials are not consistent with the date and initials observed on the dressing on 12/8/14. This indicated the treatment was not completed as charted on 12/7/14.</p> <p>Review of the current facility policy, dated 1/2013, titled "Skin Practice Guide", provided by the DON on 12/8/14 at 10:45 a.m., included, but was not limited to, the following:</p> <p>"...Wound Management</p> <p>Treatments</p> <p>Dressing selection is based upon wound type tissue type need to contain exudate need to protect wound bed need to minimize pain treatment goals protection of peri-wound area</p> <p>... Dressing changes are performed using non-sterile, clean techniques unless otherwise ordered by the attending physician....</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000325 SS=G	<p>...documentation --completion of treatments are documented on the Treatment Administration Record immediately after being performed.</p> <p>dressings are dated and initialed...."</p> <p>This federal tag relates to Complaint IN00160549 and IN00160017.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to ensure a system was in place to monitor nutritional interventions ordered to prevent further weight loss for 1 of 2 residents (Resident #D) reviewed who had lost weight and failed to ensure a resident was given replacement nutrition for food uneaten</p>	F000325	<p><b>F325 Maintain Nutrition Status Unless Unavoidable</b></p> <p>It is the center's practice to comply with the requirements of F325 – Maintaining Nutrition Status Unless Unavoidable</p> <p><b>What corrective action(s) will be accomplished for those residents</b></p>	01/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>during dialysis treatments for 1 of 1 dialysis resident (Resident #B reviewed for nutritional services in a sample of 6.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #D was reviewed on 12/3/14 at 1:40 p.m. Diagnoses for the resident included, but were not limited to, intracerebral hemorrhage with hemiplegia, diabetes mellitus, and muscle weakness. The clinical record indicated the resident received hospice services.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 9/30/14, indicated Resident #D was severely cognitively impaired and required the assistance of the staff for all activities of daily living.</p> <p>A health care plan problem, revised on 7/29/14, indicated Resident #D was at nutritional risk due to diabetes mellitus, dysphagia, depression, and diuretic use. One of the approaches for this problem was for the staff to encourage and assist as needed to consume all foods and/or supplements and fluids offered at and between meals.</p> <p>Weight records for Resident #D indicated the resident weighed 124.2 pounds on</p>		<p><b>found to have been affected by the deficient practice?</b></p> <p>Resident B: No longer resides at the facility</p> <p>Resident D: Resident was reassessed and reviewed by the Registered Dietician to validate that diet and current supplements remained appropriate. Based on the assessment, clinical record was reviewed and updated as needed. The electronic charting system was modified to allow for documentation of supplements by CNA's, as well as the Medication Administration Record supplements administered by a licensed nurse.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>Residents that receive nutritional supplements and have significant weight loss have the potential to be affected by this alleged deficient practice.</p> <p>The clinical records for all residents that receive nutritional supplements and have significant weight loss been reviewed to ensure proper documentation is present in the record for meal and supplement consumption. Those identified with less than desired intakes were referred to Registered Dietician for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>9/5/14 and 113.2 pounds on 11/18/14. The weight record indicated this was a 7.5% weight loss during that time period.</p> <p>A dietary telephone order, dated 11/21/14, indicated the Registered Dietician (RD) had evaluated the resident and made the following recommendations: Pro Mod [a protein supplement] 30 cc (cubic centimeters) three times daily, frozen nutritional treat 2 times daily with lunch and dinner, and cottage cheese with lunch related to weight loss and wounds. The clinical record indicated these orders were obtained on 11/24/14.</p> <p>The clinical record lacked any documentation of the extra cottage cheese and/or frozen nutritional treats having been given as ordered by the physician related to the resident's weight loss.</p> <p>The DON was interviewed 12/4/14 at 3:20 p.m. Additional information was requested related to the lack of documentation of the weight loss interventions noted for Resident D. She indicated interventions given by the nursing staff between meals or during medication passes were recorded on supplement consumption records and/or medication records. She indicated weight</p>		<p>further assessment and interventions</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>Residents assessed by the Registered Dietician for significant weight losses will be reviewed with the IDT to discuss new interventions, including the addition of supplements. Based on this information, the Director of Care Delivery or designee will conduct record validations to ensure that supplements have been added to the electronic record to facilitate documentation compliance.</p> <p>Licensed Nursing staff and Certified Nursing Assistants have been educated on the documentation of meal consumption to include alternate replacements and documentation of supplements. Staff who fails to comply with these expectations will be re-educated and/or progressive disciplinary action taken as needed.</p> <p>The Director of Care Delivery or designee will conduct chart reviews of meal intake documentation for a total of 20 per week to ensure it includes documentation of alternate offered and consumption of supplements when applicable. Findings will be recorded on the QAA audit tool.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>loss interventions given with meals were not monitored and she had no information to provide to document they had been provided as ordered and/or accepted.</p> <p>2. The clinical record for Resident #B was reviewed on 12/3/14 at 12:30 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus with renal manifestations, end stage renal disease, gastric esophageal reflux disease, and depressive disorder.</p> <p>The clinical record indicated the resident had been admitted to the hospital from the dialysis center on 12/1/14 due to bleeding from the dialysis graft site.</p> <p>A quarterly MDS assessment, dated 9/26/14, indicated Resident #B required extensive assistance of one staff member for eating.</p> <p>A health care plan problem, revised on 12/1/14, indicated Resident #B was at nutritional risk due to diagnoses which included, but were not limited to, diabetes mellitus, end stage renal disease, vision problems, One of the approaches for this problem was for the staff to provide diet as ordered.</p> <p>A health care plan problem, dated 7/5/14,</p>		<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process</p> <p><b>By what date the systemic changes will be completed?</b> January 7, 2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the resident needed to be up for meals, was "unable to feed herself in order to prevent malnutrition and prevent choking hazard, staff to feed res at meals in intermediate dining room".</p> <p>Weight records for Resident #B indicated the resident weighed 167.4 pounds on 6/21/14 and 156 pounds on 10/2/14. The weight record indicated this was a 7.5% weight loss during that time period. The weight record indicated the resident weighed 148.6 pounds on 11/26/14. The weight record indicated this was a 10% weight loss since the 6/21/14 weight was recorded. This indicated the resident had lost 18.8 pounds from 6/21/14 through 11/26/14.</p> <p>The clinical record indicated the resident went out to the dialysis center 3 times a week for dialysis treatments.</p> <p>A dietary timeline record, provided by the Registered Dietician (RD) on 12/4/14 at 2 p.m., included, but was not limited to, the following:</p> <p>"...8/1/14 - Weight review/Dialysis review</p> <p>Determined at this review resident was not receiving sack lunch at dialysis. Spoke with Renal Dietician due to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reports of not eating sack lunch. Dialysis to assist with set up of meals...</p> <p>...11/21/14 - Weight review/Dialysis review</p> <p>Called Renal Dietitian due to reports of resident not receiving sack lunch again. Resident was placed on alert charting for sack lunch...."</p> <p>A RD nutritional note, dated 11/21/14 at 2:15 p.m., included, but was not limited to, the following: "...Resident goes to hemodialysis M, W, F [Monday, Wednesday, and Friday]. Resident is on CHO [carbohydrate] controlled/high protein renal diet with variable po [oral] intake 25-100%. Resident receives sack lunch on dialysis days.... Resident does not always consume sack lunch d/t [due to] vision problems at dialysis. Resident is on alert charting for sack lunch. Should resident return from dialysis without consuming sack lunch, writer is to be notified so nutrition can be provided and dialysis notified...."</p> <p>A RD nutritional note, dated 11/24/14 at 10:50 a.m., included, but was not limited to the following: "Spoke with dietician at dialysis regarding resident's behavior and eating habits while at dialysis. Resident tends to return to facility with sack lunch</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>not consumed.... Resident has vision problems and dialysis center sets her up for lunch once dialysis begins. Dietician stated resident tends to sleep and cry through dialysis. If resident is asleep they let her sleep. If resident is awake they set up the sack lunch for resident. Resident does not respond well to set up. Resident will tend to leave food in front of her untouched...."</p> <p>The November 2014 food consumption record for Resident #B lacked any information related to the amount of the sack lunch consumed by the resident during the noon meal on her dialysis days. The record contained the letters "OF" where the percentage of meal eaten should be recorded. The code key indicated this meant the resident was "unavailable" for the meal.</p> <p>RN #1 (the Unit Manager for Resident #B's unit) was interviewed on 12/4/14 at 9:45 a.m. She indicated the resident had severe vision impairment. The resident required assistance with eating. The dialysis center would assist with setting up the meal at times, but would not assist the resident with eating d/t the nature of their work with blood products. She indicated this had been a long term problem and she had attempted to change the resident's dialysis times, but had been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>unable to do so. RN # 1 also indicated the sack lunch was frequently returned to the facility uneaten or partially eaten. Staff were supposed to offer replacement to the resident if needed. There was no system in place to record the amount of food eaten a dialysis or any food replaced for the amounts uneaten when the sack lunch was returned.</p> <p>She thought the resident's daughter had been going to the dialysis center to assist her with her meal, but the daughter had moved and she had no idea if she was still assisting the resident or not. The problem of the sack lunch returning unopened had been much worse over the last 7-10 days.</p> <p>The RD was interviewed on 12/4/14 at 11:05 a.m. She had talked with the dietician at the dialysis center on several occasions. She was unaware of the resident's daughter ever going to dialysis to feed the resident. The dialysis center would set up the sack lunch if the resident was awake, but would not feed her. She further indicated she had been notified that the sack lunch was coming back uneaten and had put the resident on alert charting about 10 days ago so the meal could be replaced if uneaten. She had been notified only one time during that time period that the resident had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000514 SS=D	<p>returned with the sack lunch uneaten.</p> <p>This federal tag relates to Complaint IN00160549 and IN00160017.</p> <p>3.1-46(a)(1)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on clinical record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented in regards to nursing notes and meal replacement information for 2 of 3 residents reviewed for complete and accurate clinical record documentation in a sample of 6. (Resident #D and #E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #E</p>	F000514	<p><b>F514 Resident Records complete/accurate/accessible</b></p> <p>It is the practice of the center to comply with the requirements of F514 – Resident Records complete/accurate/accessible.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident E: No longer resides at the facility</p>	01/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was reviewed on 12/3/14 at 1:50 p.m. Diagnoses for the resident included, but were not limited to, debility, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>A post fall assessment, dated 12/1/14 at 12:40 p.m., indicated the resident had been found on the floor of her room and had fallen from her bed on 11/30/14 at 7:30 a.m.</p> <p>The nursing notes lacked any information related to the resident having been found on the floor of her room and/or any assessment information completed at the time of the fall.</p> <p>RN #2 was interviewed on 12/4/14 at 3 p.m. He indicated he was the nurse on duty at the time of the resident's fall on 11/30/14 at 7:30 a.m. He indicated he completed the incident report, contacted the resident's physician and family, and started the neurochecks checklist in regards to the resident's fall. He indicated he forgot to chart any of this information in the clinical record at the time it occurred.</p> <p>2. The clinical record for Resident #D was reviewed on 12/3/14 at 1:40 p.m. Diagnoses for the resident included, but were not limited to, intracerebral</p>		<p>Resident D: Resident was reassessed and reviewed by the Registered Dietician to validate that diet and current supplements remained appropriate. Based on the assessment, clinical record was reviewed and updated as needed. The electronic charting system was modified to allow for documentation of supplements by CNA's, as well as the Medication Administration Record supplements administered by a licensed nurse.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>Residents that have had an incident have the potential to be affected by the alleged deficient practice.</p> <p>The clinical records for all residents with incidents in the past 30 days have been reviewed and reflect appropriate documentation of physician and family notification.</p> <p>Residents that receive nutritional supplements and have significant weight loss have the potential to be affected by this alleged deficient practice.</p> <p>The clinical records for all residents that receive meal intake have been reviewed to ensure</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>hemorrhage with hemiplegia, diabetes mellitus, and muscle weakness.</p> <p>Food consumption records for November, 2014 Resident #D indicated the resident ate only 25% of her meal on the following dates and times:</p> <p>Breakfast - November 7, 24, and 29, 2014 Lunch - November 7, 11, 15, 17, 18, 20, 21, 22,23, 24, 25, 26 and 28, 2014 Supper - November 1, 2, 5, 8, 15, 17, 19, 21, 22, 23, and 24, 2014</p> <p>Notations on the consumption records indicated a replacement was offered, but refused on all occasions.</p> <p>A separate "Document Amount of Meal Taken" report for November, 2014, provided by the DON on 12/3/14 at 4 p.m., indicated only 25% of the resident's meal was consumed on the dates noted. This form contained a section for documentation of "Amount of alternate meal consumed". The form indicated "Response Not Required" for all the dates noted which indicated it was not necessary to offer a replacement.</p> <p>The DON was interviewed on 12/8/14 at 9:35 a.m. She indicated she was unable to provide any additional information</p>		<p>proper documentation is present in the record for meal consumption and supplement consumption.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>Progress notes will be reviewed daily during morning meeting to assist in the identification of situations, events, or incidents. Residents who have been identified with issues or concerns will be discussed by the IDT; concerns regarding documentation will be addressed and corrected as needed to sustain compliance.</p> <p>Licensed Nursing staff has been re-educated on the Fall Practice Guidelines to include physician and family notification documented in the clinical record.</p> <p>Licensed Nursing staff and Certified Nursing Assistants have been educated on the documentation of meal consumption to include alternate replacements and documentation of supplements.</p> <p>The Director of Care Delivery or designee will conduct observations for a total of 10 per week to ensure Nurses are documenting incidents and follow</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/08/2014
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>related to the discrepancies between the two alternate meal consumption documents for Resident #D noted above. She indicated an alternate meal/supplement was to be offered to any resident who ate 25% or less of their meal.</p> <p>3. Review of the current facility policy, dated 8/2009, titled "Timeliness", provided by the DON on 12/8/14 at 9:40 a.m., included, but was not limited to, the following:</p> <p>"Chart entries are made prior to the conclusion of the shift during which patient care was given. Each entry into the narrative note delineates the date and time the note is written. If the information is documented during the shift as a summary of an event or of a patient's status at an earlier time in the shift, such as the patient's condition upon admission, the entry is identified with the present time and identifies the actual time of the event in the narrative note. The note is documented as close to the time of the event as possible..."</p> <p>This federal tag relates to Complaint IN00160549 and IN00160017.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>		<p>up assessments and notification in the clinical record. Findings will be recorded on QAA audit tools.</p> <p>The Director of Care Delivery or designee will conduct chart review of meal intake documentation for a total of 20 per week to ensure it includes documentation of alternate offered and consumption of supplements, when applicable. Findings will be recorded on the QAA audit tools.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process.</p> <p><b>By what date the systemic changes will be completed?</b> January 7, 2015</p>		

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

PRINTED: 12/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/08/2014
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	