STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
F 0000 Bldg. 00	This visit was for the Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: November 30 and December 1, 2, 3, 4, 8, 9 & 10, 2015. Facility number: 001149 Provider number: 155618 AIM number: 200145500 Census bed type: SNF: 32 SNF/NF: 30 Residential : 88 Total: 150 Census payor type: Medicare: 11 Medicaid: 30 Other: 21 Total: 62 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on December 15, 2015.	F 0000	**This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparations and execution of this response and 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. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
F 0242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure a resident was able to choose her shower preferences for 1 of 3 residents reviewed for choices. (Resident #4) Findings include: During a resident interview on 12/1/15 at 9:54 a.m., Resident #4 indicated she did not know when her shower days were and the CNA's would not tell her because they indicated they did not know. She indicated she preferred to take a shower and the CNA's gave her a bath instead. Resident #4's record was reviewed on 12/03/2015 at 11:38 a.m. Diagnoses included, but were not limited to, multiple sclerosis, neuromuscular dysfunction, and dysphagia The Task Kardex dated 9/29/15, indicated the resident's shower days were on Monday and Thursday evenings.	F 0242	**Corrective Actionsfor residents affected:** Resident #4 was interviewed as to her showerday preferences. Resident #4 Care Planand Kardex have been updated to reflect her preference. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Residents have the potential to be affected. b) Interview-ableresidents will be asked whether they are satisfied with their current showerschedules. Changes to their showerschedules will be made according to their preferences. Resident Care Plans and Kardex will beupdated accordingly to reflect their choices. **What measures will beput into place or what systemic changes will be made to ensure that the deficientpractice does not recur:** 1.Residents will be interviewed upon admission todetermine their	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	There was no bathing preference listed. The resident has a Care Plan dated 8/23/15, which addressed the problem with ADL (Activity of Daily Living) Self Care deficit as evidenced by total dependence related to the disease process of multiple sclerosis. The interventions indicated "8/23/15... Assist to bathe/shower as needed, Assist with daily hygiene, grooming, dressing, oral care and eating as needed...." During an interview on 12/9/15 at 4:00 p.m., CNA #4 indicated the resident should have a shower twice a week and she thought her shower days were on Tuesdays and Fridays. She indicated the resident used a shower bed when she was showered. During an interview on 12/10/15 at 3:34 p.m., the Quality Assurance Specialist indicated the resident's Plan of Care (Kardex) was updated in the computer to reflect what her preferences for bathing were now, so the staff knew her shower preferences. 3.1-3(u)(1)		preference for bath/shower schedule. These choices will be reflected on their CarePlan and Kardex. 2.Nursingstaff will be re-educated regarding resident preferences in regards tobath/shower and indication on Care Plan and Kardex. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:** 1.ADNS/designee will interview/audit residents weekly x 4weeks, then monthly to ensure resident choices are honored. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to assurecompliance.	
F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure activities were followed according to residents Care Plans and failed to ensure individual activity program needs were met for 3 of 4 residents reviewed for activities. (Residents #20, #57 and #14) Findings include: 1. On 12/1/15 at 2:03 p.m., Resident #20 was observed sitting in her wheelchair facing the nurses station instead of the T.V. with her head down and her eyes closed. The T. V., was playing a talk show called "The Talk" with the volume low. Bible Study was the activity Resident #20's record was reviewed on 12/3/15 at 11:17 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavioral disturbance and major depressive disorder. The resident had a Care Plan dated 7/11/13, which addressed the problem she enjoyed activities such as magazine/newspaper reading, flower gardening and arrangements, all music,	F 0248	**Corrective Actionsfor residents affected:** 1.Residents # 20, 57, and 14 has had a new comprehensiveassessment completed to identify the interest of each of these residents, havehad their care plans updated to reflect the individualized needs of thoseresidents and the activity logs for these residents activities have been revisedto reflect accurate documentation for residents. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Residents residing in the facility have the potentialto be affected. 1.Residents will have a new comprehensive assessmentcompleted to identify the interest of each resident. Changes to each residents Care Plans will beupdated accordingly to reflect their choices. 2.Activity logs will reflect proper documentation ofactivities received by each resident according to their care plans.	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	pets/animals, group activities, outdoors, and religious/spiritual. Interventions included "7/11/13--Assist to transport to & [and] from activities of choice, Attend Activity Therapy exercise programming and observe group, 3/23/15--encourage resident to continue to attend structured activity programs such as current events and use cues to assist with learning and recall. Provide supplies/materials for leisure activities as needed/requested such as magazines." The most current "Recreation/Activity Evaluation" dated 4/8/14, indicated the resident liked to keep busy, enjoyed participating in independent leisure activities, involved/expressed interest in group leisure activities, enjoyed participated in outdoor leisure activities. The Leisure Pursuits/Interests included current interests were animals/pets, arts and crafts, children/intergenerational, exercise/physical activities, gardening/plants, community involvement, music, outdoor activities/ parties/socials, religious involvement, talking/conversing, TV/radio. Her past interest included cards/games, cooking/baking, current events/news, reading/writing and travel/outings. The no interest area included computer/tablet use, movies and puzzles/word games.		**What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.Activities staff will be re-educated regarding residentpreferences in regards to activities and the implementation on the Care Plan. Additionally, activities staff will bere-educated as to communication/documentation of activities offered andprovided. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:** 1.Activities Director/designee will do random interviews/auditfor residents weekly x 4 weeks, then monthly times 2 months to ensure residentchoices are honored. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to assurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	An "ADL's [Activity of Daily Living] Functional Status" dated 3/4/15 at 5:18 p.m., indicated the resident's cognitive skills were severely impaired. She was up daily in her wheelchair and propelled herself throughout the unit and "often wanders the unit with no real purpose." A Recreational Services Quarterly note dated 9/29/15 at 12:40 p.m., indicated the resident's activity interests were met by observing socials, peers and visitors interact throughout the day. She enjoyed passively attending current events, movies, crafts and trivia and games. She observed and made crafts her family brought into her such as; decorating tennis shoes. A Quarterly MDS (Minimum Data Set) Assessment dated 9/30/15, indicated the resident's BIMS (Brief Interview Mental Status) was a 3, which indicated she was severely cognitively impaired. A Significant change MDS assessment dated 12/31/15, indicated the Preferences for Routine and Activities were conducted and indicated: How important is it to you to have books, newspapers and magazines to read? Not important at all. How important is it to you to listen to music you like? Not very important			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	How important is it to you to be around animals such as pets? Somewhat important. How important is it to you to keep up with the news? Not important at all. How important is it to you to do things with groups of people? Somewhat important. How important is it to you to do your favorite activities? Somewhat important. How important is it to go outside to get fresh air when the weather is good? Somewhat important. How important is it to you to participate in religious services or practices? Not very important. The "Daily Recreation/Activity Participation Documentation" log dated November 2015, indicated the resident participated in these activities: Passively participated in cards/games on November 1, 7, 13 through 15 and 27. She actively participated in current events on November 1 through 30. She passively participated in exercise on November 6, 20 and 22. She actively participated in the leisure cart (Ice Cream activity) on November 6, 13, 20 and 27. She actively participated on movies on November 1 through 30. She actively participated in music/singing on November 8.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	She passively participated in socializing on November 1 through 30. She actively participated in special and theme events on November 8, 15 and 26. She actively participated in television on November 1 through 30. She actively participated in visitors on November 20,21, 26 and 28. She actively participated in mail on November 21. She actively participated in room visits on November 1 through 30. The resident's activity participation log failed to indicate she had documentation she had participated in activities she liked to participate in: Spiritual/Religious activities, gardening activities, sensory stimulation and pet visit activities and she only had one music activity documented for the entire month. The "Daily Recreation/Activity Participation Documentation" log dated December 2015, indicated the resident participated in these activities: Passively participated in cards/games on December 4, 5 and actively participated on December 3. She actively participated in current events on December 1 through 8. She passively participated in exercise on December 5 and 6. She actively participated in the leisure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	cart (Ice Cream activity) on December 4. She actively participated on movies on December 1 through 8. She actively participated in pet visits on December 3. She actively participated in sensory stimulation on December 3. She passively participated in socializing on December 1 through 8. She actively participated in television on December 1 through 8. She actively participated in visitors on December 3, 5 and 6. She actively participated in mail on December 3. She actively participated in room visits on December 1 through 8. The resident's activity participation log failed to indicate she had documentation she had participated in these activities she liked to participate in: music activities, gardening and arrangement and religious and spiritual activities. On 12/3/15 at 10:15 a.m., the resident was observed sitting in her wheelchair in the back of the resident lounge with the T. V., playing a game show and she had her back towards the T. V., facing the independent dining room. There was no activity staff in the lounge to engage her in the T.V. activity.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	On 12/3/15 at 10:26 a.m., the resident was observed propelling herself in her wheelchair toward the assist dining room. On 12/3/15 at 10:45 a.m., the resident was observed sitting at a table on the other side of the nurses station (approximately over 20 feet from the location the activity was occurring) drinking her Ensure supplement while the News and Views activity was occurring in the resident lounge. On 12/3/15 at 1:56 p.m., the resident was sitting in her wheelchair in the resident lounge with the T. V., playing a soap opera. She was sitting with her back toward the T.V., facing the independent dining room with her head down and her eyes closed. There was no activity staff in the lounge to engage her in the T.V. activity. On 12/4/15 at 9:56 a.m., the resident was observed sitting in the resident lounge in her wheelchair with her head down and her eyes closed. The T.V., was playing the "Today" show. There was no activity staff in the lounge to engage her in the T.V. activity. On 12/4/15 at 10:49 a.m., the resident was observed sitting in her wheelchair with her head down and her eyes were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	closed during the News and Views activity while the Activities Assistant (AA) #10 was reading from the newspaper. AA #10 was asking questions of other residents, but he did not engage Resident #20 in the conversation. On 12/8/15 at 10:09 a.m., the resident was observed sitting in her wheelchair at the back of the resident lounge with her head down and her eyes closed. The T.V., was playing "Lets Make a Deal." There was no activity staff in the lounge to engage her in the T.V. activity. On 12/8/15 at 10:30 a.m., the Activity Director was observed reading the newspaper for the News and Views activity. The resident was in the back of the resident lounge and she had her head down and her eyes was closed. The resident was not being engaged in the activity. Other residents were answering the Activity Director's questions. On 12/08/2015 at 11:18 a.m., the Activity Director finished the Poetry activity, then she turned on "The Price is Right" show on the T.V. The resident was observed sitting at the back of the room with her head down and her eyes closed. There was no activity staff in the lounge to engage her in the T.V activity.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	On 12/8/15 at 2:28 p.m., the resident was observed sitting in the resident lounge with her head down and her eyes closed. The T.V. was playing a soap opera and no activity staff was in the lounge to engage her in the T.V. activity. On 12/8/15 at 3:40 p.m., the resident was observed sitting by the elevator in front of the nurses station in her wheelchair with her head down and her eyes closed while AA #9 was leading the "Holiday Brainstorming Ideas" activity. During an interview on 12/8/15 at 3:27 p.m., the Activity Director indicated the resident did not like to sit up close with everyone else during the activities, but she had failed to document this in her Recreational Service notes. She indicated she did not have that many individualized activities for this resident. She indicated this resident was not on a one on one activity program. During an interview on 12/10/15 at 12:54 p.m., the Activities Director indicated the resident received visits from her church and she documented these visits under the visitors area on the Activity participation log, not the Spiritual/Religious area.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	2. On 12/1/15 at 2:23 p.m., Resident #57 was observed sitting in his self propelling broda chair in the towards the back of the resident lounge. The T.V. was playing a talk show called "The Talk." The activity scheduled for 2:00 p.m., was Bible study. There was no activity staff in the lounge to engage him in the T.V. activity. Resident #57's record was reviewed on 12/8/15 on 8:26 a.m. Diagnoses included, but were not limited to, dementia with Lewy bodies, difficulty in walking, muscle weakness, cerebrovascular disease and delirium due to known physiological condition. The resident had a Care Plan dated 8/13/14, which addressed the problem the resident would be offered the option to participate in activities of his choice. Interventions indicated "8/13/14... Encourage participation in group activities of interest, 8/14/14--Offer redirection and diversion as needed, Provide supplies/materials for leisure activities as needed/requested." A current "Recreation/Activity Evaluation" dated 8/14/15, indicated the resident liked to keep busy, he enjoyed and participated in independent leisure activities, he was involved and expressed interest in group leisure activities, he			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	enjoyed and participated in outdoor leisure activities. His current interests were animals and pets, children and intergenerational, exercise and physical activities, music, reading and writing, talking and conversing, T.V. and radio, he pursued recreation and leisure pursuits with assistance. His past interests were current events and the news, movies, community involvement, parties and socials, religious involvement, travel and outings. He had no interests in arts and crafts, cards and games, computer and tablet use, cooking and baking, gardening and plants or puzzles and word games. A Significant Change MDS Assessment dated 4/29/15, indicated Preferences for Routine and Activities indicated: How important is it to you to have books, newspapers, and magazines to read? Not very important. How important is it to you to listen to music you like? Somewhat important. How important is it to you to be around animals such as pets? Not very important. How important is it to you to keep up with the news? Somewhat important. How important is it to you to do things with groups of people? Not very important How important is it to you to do your favorite activities? Somewhat important.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	How important is it to you to go outside to get fresh air when the weather is good? Not very important. How important is it to you to participate in religious services or practices? Somewhat important. A Quarterly MDS Assessment dated 7/29/15, indicated the resident's BIMS score was 6, which indicated he was severely cognitively impaired. A Social Service Note dated 12/29/14 at 1:23 p.m., indicated this was a Quarterly assessment. "...Res appears very HOH [hard of hearing] making it difficult to determine if res cannot answer interview questions r/t [related to] cognitive impairment or poor hearing.... A Quarterly Recreational Service note dated 7/29/15, indicated the resident's activity interests were met with him propelling his wheelchair on the unit, observing peers and visitors in the living room, loitering near the nurses station, passively attending current events, social and music programs. A current Recreation/Activity Evaluation dated 8/14/15, indicated he enjoyed and participated in group leisure activities, outdoor leisure activities, animals/pets, children/intergenerational,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	exercise/physical activities, music, reading/writing, talking/conversing, TV/radio, and his past interests were current events/news, movies, community involvement, parties/socials, religious involvement, travel/outings. He had no interests in arts and crafts, cards/games. A Quarterly Recreational Service note dated 10/28/15 at 1:53 p.m., indicated the resident's activity interests were met as a passive participant in current events, trivia, socials and music and entertainment. The Daily recreation/Activity Participation Documentation log dated November 2015, indicated the resident participated in these activities: He passively participated in cards/games on these dates November 1, 7, 13 and 15. He actively participated in current events on November 1 through 14, 16 through 19 and passively participated on 15, 20 through 26 and 30. He passively participated in Exercise on November 6, 20, 22, and 30. He was unavailable to participate in the leisure cart (Ice Cream activity) on November 6, 13, 20 and 27. He actively participated on movies on November 1 through 30. He actively participated in music/singing on November 8.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	He passively participated in socializing on November 1 through 14, 22 through 25 and passively participated from 15 through 21 and 26 through 30. He actively participated in special and theme events on November 8 and passively participated on November 15. He actively participated in Television on November 1 through 30. He actively participated in room visits on November 1 through 30. He had no Sensory Stimulation or pet visits in the month of November. The residents Care Plan indicated he enjoyed activities such as; activity interests of his choice and to participate in outdoor hot/cold weather activities. His Recreation/Activity Evaluation dated 8/14/15, indicated he enjoyed to participate in group leisure activities, outdoor leisure activities, animals/pets, children/intergenerational, exercise/physical activities, music, reading/writing, talking/conversing, TV/radio, and his past interests interests were current events/news, movies, community involvement, parties/socials, religious involvement, travel/outings. He had no interests in arts and crafts, cards/games. His activity participation log dated November 2015, indicated he passively participated in cards/games 4 times this month, he participated in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	exercise once this month, there was no off site outing, no sensory stimulation, no pet visits, and no Spiritual/Religious activities. The Daily recreation/Activity Participation Documentation log dated December 2015, indicated he participated in these activities: Resident #57 passively participated in current events on December 3 and 5 through 8. He actively participated in movies on December 1 through 8. He passively participated in socializing on December 1 through 8. He actively participated in Television on December 1 through 8. He actively participated in room visits on December 1 through 8. The residents Care Plan indicated he enjoyed activities such as activity interests of his choice and to participate in outdoor hot/cold weather activities. His Recreation/Activity Evaluation dated 8/14/15 indicated he enjoyed to participate in group leisure activities, outdoor leisure activities, animals/pets, children/intergenerational, exercise/physical activities, music, reading/writing, talking/conversing, TV/radio, and his past interests interests were current events/news, movies,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	community involvement, parties/socials, religious involvement, travel/outings. He had no interests in arts and crafts, cards/games. His activity participation log dated December 2015, indicated he did not participate in current events daily, he did not participate in any music activities, he did not participate in any sensory stimulation activities or Spiritual/Religious Activities. On 12/3/2015 at 10:15 a.m., the resident was observed in the resident lounge sitting in his self propelling broda chair with the T.V. on a game show. The resident's head was down leaning on his left hand and his eyes were closed. There was no activity staff was in the lounge engaging him in the T. V. activity. On 12/3/15 at 10:30 a.m., AA #10 was observed taking the resident's self propelling broda chair by the back bar and rolled him backwards away from the T.V., and the other resident's in the front of the resident lounge (approximately 160 inches/13.3 feet) and the resident started yelling "Let's Go" "Lets Go" "Lets Go." AA #10 left the resident sitting in the back of the lounge and began reading from the newspaper during News and Views activity. AA #10 did not engage Resident #57 during this activity.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	On 12/3/15 at 1:56 p.m., the resident was observed sitting in the resident lounge in his broda chair with the T.V., playing a soap opera with his head down and his eyes closed. There was no activity staff in the lounge to engage him in the T.V. activity. On 12/3/15 at 2:33 p.m., the resident was observed sitting in his broda chair in front of the T.V., which was playing the movie "Benjamin Buttons." He was sitting in his self propelling broda wheelchair with his head down and his eyes closed. There was no activity staff in the lounge to engage the resident in the movie activity. On 12/4/15 at 9:58 a.m., the resident was observed laying in bed asleep. On 12/8/15 at 8:37 a.m., the resident was observed in his bed. On 12/8/15 at 10:09 a.m., the resident was observed laying in his bed with his eyes open. There was a program "Let Make A Deal" a game show on the T.V., in the resident lounge at that time. On 12/8/15 at 10:30 a.m., the resident was observed in bed at that time and the Activity Director was reading the newspaper during the News and Views			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	activity. On 12/8/15 at 11:43 a.m., the resident was observed being sat in the back of the resident lounge while the T.V., was playing "The Price is Right." On 12/8/15 at 2:34 p.m., the resident was observed sitting in the resident lounge with a soap opera playing on the T.V. He had his head down and his eyes was closed. On 12/8/15 at 3:40 p.m., the resident was observed sitting in his broda chair in the resident lounge with his head down and his eyes closed while AA #9 was performing the Holiday Brainstorming Idea activity. AA #9 did not engage Resident #57 in this activity. During an interview on 12/8/15 at 3:27 p.m., the Activity Director indicated she did not have that many individualized activities for this resident. She indicated this resident was not on a one on one activity program. She indicated the resident did not have many visitors. During an interview on 12/9/15 at 4:10 p.m., the Activities Director indicated the Current Events activity was the same as the News and Views activity in the morning. She indicated on Thursdays she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	played the movies. She indicated the Room visit activity is usually completed by her and AA #10 by popping into the residents' rooms with their mail and a leisure cart asking the residents if they need anything and telling them about the morning activities were and if they were coming. She indicated they usually ended up spending more time with the cognitively intact residents because they could voice their wants and needs when they were doing the room visits better than the cognitively impaired residents. She indicated she had tactile stimulation two times a week, which she used to do three times a week for the cognitively impaired residents. She indicated the T.V., activity was when the residents were sitting in front of the T.V. and watching T.V. programs. She indicated yesterday (12/8/15) when she indicated passive participating was the residents who had their eyes closed and the residents were not participating, she had forgotten sometimes the residents will have their eyes closed, then they will open their eyes and call out an answer. She indicated the alert and oriented residents close their eyes, then open them and call out answers, but not the cognitively impaired residents. She indicated the leisure cart had hand lotion on it to do hand massages for the cognitively impaired residents. She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	indicated socializing was when the residents talked with other resident and she took residents out for strolls in their wheelchairs. She indicated the cards/games activity was like the balloon toss game. During an interview on 12/10/15 at 12:54 p.m., the Activities Director indicated the resident received visits from the Catholic church and she documented these visits under the visitors area on the Activity participation log, not the Spiritual/Religious area. A current policy titled "Patient Assessment and Documentation" dated January 2013, provided by the Administrator on 12/10/15 at 12:54 p.m., indicated "Activity and Recreation Documentation... Individualized plans of care address and support the patient's meaningful lifestyle...Activity/Recreation Evaluation: The activity and recreation staff completes the Activity/Recreation Evaluation... for each newly admitted patient. This evaluation reviews the patient's current mental, medical, functional status and interests for the design and implementation of a comprehensive patient care plan. The initial Activity/Recreation Evaluation is completed between the day of admission and the fifth business day of the patient's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	stay and also annually with the MDS re-assessment process to reflect current information... Section F-Preferences for Customary Routine and Activities: This section requires an interview which allows for the patient to state what things are important for his/her ability to maintain a distinct lifestyle...." 3. On 12/3/15 at 10:51 a.m., the record review for Resident #14 was completed. Diagnoses included, but were not limited to, hypothyroidism, Alzheimer. On 12/3/15 at 10:30 a.m., the resident was observed sitting in the lounge area with a magazine in her hand, was occasionally looking at TV., Activities staff came in and was talking about the news. The Activity Care Plan dated 4/16/15, indicated the resident enjoyed activities such as games, general family story reading, variety of music, pets/animals, group activities, religious spiritual...arrange for seating closer to leader of activity programs as resident is hard of hearing. Assist in planning and/or encourage to plan own leisure time activities, assist to transport to and from other activities of choice, attend activity therapy exercise programming, and encourage participation in group activities of interest.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	On 12/3/15 at 3:10 p.m. the resident was observed sitting watching the movie activity and was seated 10 feet from the television. A staff member walked by and said something to her and she responded "what?'. The staff member was observed having to stop and lean closer to the resident and talk to her face to face for the resident to understand them. On 12/08/15 at 10:45 a.m., the resident was observed with her head down while the Activities Director(AD) was reading the newspaper and discussing with other residents. On 12/8/15 at 11:46 a.m., CNA #1 was observed telling the resident she was going to take the resident to the dining room. The resident twice stated, "what I cant understand you?" On 12/8/15 at 2:23 p.m., the space measured 10 feet between where Activity Director was positioned and where the resident was sitting during the current events activity. During an interview on 12/08/15 at 3:19 p.m., the AD indicated she had not really asked the resident any questions to see if she was able to hear during an activity.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	She also indicated the resident would be considered active for an activity if they were making eye contact and responding verbally to questions. 3.1-33(a) 3.1-33(b)			
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure the Social Services Director (SSD) followed up to ensure a resident received psychiatric services in a timely manner following a Psychiatric hospitalization for 1 of 1 residents reviewed for Pre-Admission Screening and Resident Review (PASRR). (Resident #7) Findings include: Resident #7's record was reviewed on 12/8/15 on 11:04 a.m. Diagnoses included, but were not limited to, bipolar disorder, unspecified mood disorder, major depressive disorder, anxiety disorder and insomnia.	F 0250	**Corrective Actionsfor residents affected:** Resident #7 is currently receiving thenecessary Psychiatric Services per recommendations. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.The Social Services Director has been re-educated byAdministrator follow up to ensure Psychiatric Services are being provided. In the event that Psychiatric Service cannot be provided within thefacility, the Social Services Director will arrange for outpatient	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	A "State of Indiana Certification of PASARR/MI [Pre-Admission Screening and Resident Review/Mental Health]" dated 3/31/14, indicated the evaluation was completed on 3/27/14. The Pre-Admission Screening Determination indicated the resident is mentally ill, but does not require specialized services. The Level II diagnoses were mood disorder and anxiety disorder. The resident was to receive services of less intensity than specialized services, which were yearly resident review, psychiatric evaluation, individual therapy, medication review, medication monitoring and medication administration. A "Comprehensive Psychiatric Evaluation" from (name of hospital) dated 6/15/15, indicated the resident's chief complaint was worsening depression. A Social Service note dated 8/10/15 at 2:35 p.m., indicated the resident had some episodes of insomnia and was prescribed Trazodone. A Social Service note dated 8/24/15 at 12:36 p.m., indicated the resident had a PHQ-9 (Patient Health Questionnaire) was a 10, which indicated the potential		PsychiatricServices are provided. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.Residents with diagnosis of mental illness including“Depression” have been reviewed by the Social Services Director to ensure theyare receiving Psychiatric Services. 1.Care Plans have been updated to reflect the resident isreceiving Psychiatric Services. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:** 1.Social Services Director/designee will review/auditweekly x 4 weeks and then monthly and report all findings to QAA committee. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	for moderate depression. She indicated she had not been feeling well due to a cough and chest congestion and preferred to stay in her room. She indicated she did not want to participate in any activities at that time because she was not in the "mood" because of her cough. A Social Service note dated 9/24/15 at 12:00 p.m., indicated the resident indicated she mainly felt nervous and anxious during ADL (Activities of Daily Living) care and when the staff was using the lift to transfer her. A Social Service note dated 10/29/15 at 1:35 p.m., indicated the resident was going to yell out during transfers due to this was one of the main causes of her anxiety. A Social Service note dated 11/6/15 at 4:40 p.m., indicated the resident sought out the Social Service Assistant to indicate she felt her depression and anxiety was worsening. A Social Service note dated 11/9/15 at 3:50 p.m., indicated the resident's anxiety continued to occur during transfers and care. A Social Service note dated 11/12/15 at 5:05 p.m., indicated the resident was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	referred to (name of the Psychiatry group) for psychological/mental health evaluation and treatment. A (name of Psychiatric group) note dated 11/25/15, indicated in the new or ongoing active signs and symptoms/concerns noted by staff: the resident got upset at staff easily, ruminating thoughts about broken relationship with a family member and giving the loss of her independence and her home. Under the Summary of Session the noted indicated the resident was very talkative, tearful at times, very eager to start therapy and "find relief." The resident indicated "just knowing you're coming makes me feel better." The note indicated she was experiencing insomnia and daily anxiety exacerbations. A (name of Psychiatric group) note dated 12/9/15, indicated in the new or ongoing active signs and symptoms/concerns noted by staff: the resident has complaints, gets upset easily with staff, feels a loss of control, has depressive episodes and high anxiety. Under the Specific Interventions and Patient Responses the resident indicated the scheduled Xanax seemed to have helped with her anxiety because she no longer had to "ask and wait," which created more anxiety for her.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	During an interview on 12/10/15 at 3:03 p.m., the Social Services Director indicated the Resident #7 was on PASSR for Psychiatric services, but the facility could not get a Psychiatrist to come to the facility. She indicated the Psychiatric company she had coming to the facility had stopped coming because there were not enough residents in the facility for them to visit. She indicated after the resident was hospitalized and the Nurse Practitioner was monitoring her medications and as far as the Psychologist went, the resident only had the SSD to talk to about her psychiatric concerns. She indicated the resident did not get the Psychiatric services she should have had after her hospitalization until November because no one would come to the facility. She indicated she only had "me" when asked if any outside Psychiatric facilities were looked into for Psychiatric services after her hospitalization. 3.1-34(a)(2)			
F 0279 SS=E Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). Based on interview and record review, the facility failed to develop care plans for a resident at risk for wandering for 1 of 3 residents reviewed for accidents (Resident #8), a resident in need of range of motion for 1 of 3 residents reviewed for range of motion (Resident #70), and 2 residents prescribed psychotropic medications for 2 of 5 residents reviewed for unnecessary medications (Resident #116 and Resident #120). Findings include: 1. The record review for Resident #8 was completed on 12/08/2015 at 9:30 a.m. Diagnoses included, but were not limited	F 0279	**Corrective Actionsfor residents affected:** 1.Care Plan for Resident #8 has been updated to reflectresident at risk for wandering. 1.Care Plan for Resident #70 has been updated to reflectneed for ROM. 2. Care Plan forResidents #116 and#120 have been updated to reflect they were reviewed for psychotropicand unnecessary medications. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective**	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	to, Alzheimer's disease, depressive disorder, and non-organic psychosis. An Admission Minimum Data Set (MDS) assessment, dated 06/15/2015, indicated Resident #8 scored a 3 on the Brief Interview of Mental Status (BIMS), meaning the resident was severely cognitively impaired. It also indicated locomotion on and off of the unit required supervision, meaning the resident required oversight, encouragement or cueing. Progress notes faxed to the facility from the referring psychiatric facility on 06/04/15 indicated the following: Physician Care Notes: 5/27/25: "...[Resident] did become somewhat disoriented last night and wandered the unit and went into an unlocked room and [urinated] in a wastebasket. Of course, this is indicative of his level of confusion more than anything else...." 6/1/15: "...[Resident] last night became very re-emphatic about the need to leave. He also became distressful and suspicious...." Nursing Reassessment Notes: 5/19/15: "...[Patient] wandering - questioning why he's here et [and] where		**action will be taken:** 1.Residents have been re-evaluated to determine theirrisk for wandering and behaviors. 2.Identified Resident Care Plans have been updated toreflect findings/risks, behaviors (including wandering) and any need foradditional services. 3.Nursing staff have been re-educated on Wandering and ExitSeeking Practice Guides regarding standards of practice regarding wanderingresidents and those with behaviors. 4.Residents with decline in Range of Motion have beenidentified and screened by Rehab Services to determine need for additional ROM. 5.Those affected Resident Care Plan and Kardex have beenupdated to reflect ROM needs. 6.Clinical staff will be re-educated on company standardsof practice for performing ROM on residents with additional ROM needs. 7.Residents receiving psychotropic medications have beenreviewed and their care plans were individualized and updated to reflect use ofpsychotropic medications/unnecessary medications/potential side effects. 8.Physician orders for appropriate Psychiatric Serviceshave been received and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	his spouse is...." 5/20/15: "[Patient] wanders physically and mentally...." 5/24/15: "...Wanders a lot...." 5/29/15: "...Pacing the floors, wanders a lot...." 5/30/15: "...Wanders and paces a lot. Seems friendly and cooperative...." 5/31/15: "...[Patient] wanders often into others rooms...." 6/1/15: "...Patient wandering unit, confused...." A facility Nursing Admission Assessment, dated 6/4/14, indicated Resident #8 was cognitively impaired with mobility. The assessment indicated Resident #8 did not have a history of exit seeking or wandering. Facility Nursing Progress Notes indicated the following : 6/5/2015 12:41 a.m.: "...ambulatory independently but has history of wandering...." 06/05/2015 2:02 p.m.: "...[Resident] alert/oriented to self...[Resident] confused to place and time...[Resident] ambulates independently...[Resident] must be oriented and redirected often...." 06/06/2015 7:23 p.m.: "...CNA went to		implemented accordingly, and families have been notifiedof orders. 9.Social Services Director/designee has been re-educatedin monitoring and review of residents regarding psychotropicmedications/unnecessary medications/potential side effects and their needs andcommunicating with physicians, clinical nursing and families as needed. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.Residents will be assessed for wandering history/risksupon admission. 2.Admissions will be reviewed in QAA committee and CarePlans and Kardex will reflect plan of care. 3.Residents will be assessed for psychiatric needs andpsychoactive medications/potential side effects upon admission. 4.Admissions will be reviewed in QAA committee and CarePlans and Kardex will reflect plan of care. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	resident's room at 1600 [4:00 p.m.] and resident was not in his room. Staff started room to room checks. Checked bathrooms and behind doors and closets. CNA notified the MOD [Manager on Duty]. Sweep the premises. Received call from police at 1610 [4:10 p.m.] that resident was at [name of store]...." A Social Services progress note, dated 06/06/2015 at 5:00 p.m., indicated "...admitted to facility on 6/4/15 from [name of psychiatric care center]. According to the notes from [name of psychiatric care center] pt. [patient] was admitted on 5/18/15 with reportedly increasing memory loss as well as some difficulty redirecting...Hospital notes also stated pt. became distressful and suspicious of staff during his stay...BIMS score 3 which indicates pt. has severe cognitive impairment...." During an interview on 12/10/15 at 3:03 p.m., the Social Services Director indicated The IDT (interdisciplinary team) team reviewed information prior to an admission. Residents who were deemed to be wander and/or elopement risks tended to go to the second floor because it was more secure. Resident #8 was placed on the first floor because he was going to be a short-term stay. If a resident had a previous history of		1.ADNS/designee will monitor/audit resident admissionsand those identified at risk for wandering and their interventions in place andreview with IDT (Interdisciplinary Team) and QAA Committee weekly x 4 weeksthen monthly. 2.Rehab Services/designee will monitor/audit residentadmissions and those identified with assistance with ROM needs and interventionsin place at QAA Committee weekly x 4 weeks then monthly. 3.Social Services Director will review/audit residentadmissions and identified residents at risk and their interventions in placeand review with QAA Committee weekly x 4 weeks and then monthly. 4.Administrator will be responsible to assign anyadditional action required. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	wandering or documentation that they had tried to exit the healthcare door, the IDT team would determine the need for a wander guard. No behavior tracking for wandering, wander guard, careplan or initial plan of care was put in place for Resident #8 prior to the elopement incident on 06/06/2015. A behavior practice guide, dated 07/2015, provided by the Quality Assurance Consultant on 12/10/15 at 4:25 p.m., indicated "...Patients are evaluated upon admission for a history of, or risk factors for wandering and, or exit seeking...The interdisciplinary team evaluates the patient's history and current clinical condition to identify patients at risk for wandering or exit seeking and develops a patient specific plan of care...." 2. The record review of Resident #70 was completed on 12/08/2015 at 10:30 a.m. Diagnoses included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis. A quarterly MDS assessment, dated 11/10/2015, indicated Resident #70 had an impairment to functional range of motion on one side for upper and lower extremities. The resident participated in occupational therapy from 8/19/2015 to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	10/07/2015. A therapy follow up note, dated 10/07/2015, indicated "...apply splint to right upper extremity at nite [sic]...Active-assisted ROM [range of motion] of upper extremities during ADLs [activities of daily living]...." During an interview on 12/09/2015 at 4:24 p.m., the Director of Rehab indicated Resident #70 had participated in physical and occupational therapy on and off since 2014. Her last round of occupational therapy ended 10/07/2015. Resident #70 had right sided hemiplegia, with a flaccid right upper extremity. There was no active movement on Resident #70's right side, but the left side was within normal limits. Resident #70 wore a splint on the right hand at night for proper positioning and should have received standard range of motion daily with active assist, meaning the resident did as much as she could and staff assisted. A care plan for range of motion could not be found within the clinical record of Resident #70. During an interview on 12/10/2015 at 3:34 p.m., the Quality Assurance Consultant indicated there was a care			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	plan in place for range of motion and the splint device as of 12/10/2015, but it was not in place prior to this. 3. The record review for Resident #120 was completed on 12/08/2015 at 2:15 p.m. Diagnoses included, but were not limited to, depressive episodes and anxiety. Physician Orders were as follows: 11/5/2015 - Temazepam (a hypnotic medication) - 15 mg (milligrams), Give 1 capsule by mouth as needed for insomnia at bedtime. 11/5/2015 - Xanax (an antianxiety medication) - 0.5 mg, Give 1 tablet by mouth every 6 hours as needed for anxiety. A medication administration record (MAR), dated November 2015, indicated Resident #120 was administered Temazepam November 12, 14, 15, and 18, 2015 and was administered Xanax on November 13, 2015. During an interview on 12/10/15 at 3:03 p.m., the Social Services Director indicated residents that had a psychotropic medication should have had a psychotropic medication care plan and an order to monitor side effects on the medication administration record where			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	staff can monitor daily. A care plan addressing insomnia, anxiety and monitoring of medication side effects was not found in Resident #120's medical record. During an interview on 12/10/2015 at 4:27 p.m., the Quality Assurance Consultant indicated a care plan was added as of 12/10/2015, but there was not a prior care plan in place. 4. The record review of Resident #116 was completed on 12/08/2015 at 11:45 a.m. Diagnoses included, but were not limited to, anxiety, depression, and dementia without behavioral disturbance. A Physician's Order, dated 11/25/2015, indicated Zoloft 25 mg daily for depression. No care plan addressing psychotropic medication usage, side effect monitoring, or non-pharmacological interventions were found in Resident #116's clinical record. During an interview on 12/10/2015 at 4:27 p.m., the Quality Assurance Consultant indicated a care plan had been added to Resident #116's clinical record, however there was not a care plan in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	place prior to this time. A behavior practice guide, dated 07/2015, provided by the Quality Assurance Consultant on 12/10/15 at 4:25 p.m., indicated "...Upon completing an evaluation, the interdisciplinary team (IDT) develops a patient specific or person centered care plan...The goal of the care plan may include but is not limited to:...preventing or minimizing mood or behavioral symptom...utilization of non-pharmacological interventions...." 3.1-35(a) 3.1-35(b)(1)			
F 0312 SS=D Bldg. 00	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. Based on observation, interview and record review, the facility failed to ensure dental care and showers were completed as written on the residents plans of care for 2 of 4 residents reviewed for ADL's (Activity of Daily Living). (Resident #20 and #87) Findings include:	F 0312	**Corrective Actionsfor residents affected:** 1.Resident #20 does receive oral care at least daily. 2.Resident #87 receives shower/bath twice weeklyaccording to residents preference. **How other residentshaving the**	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	1. On 12/1/15 at 2:00 p.m., Resident #20 was observed with white debris between her upper and lower teeth and along bilateral gumlines. Her gums were observed to be reddened and inflamed. Resident #20's record was reviewed on 12/3/15 at 11:17 a.m. Diagnoses included, but were not limited to Alzheimer's disease, dementia without behavioral disturbance and major depressive disorder. A dental exam note dated 5/21/15, indicated oral hygiene was poor, the gingival tissue was inflamed and the debris level was moderate. The resident had a Care Plan dated 3/23/15, which addressed the problem dental or oral cavity related to resident needing assistance secondary to cognitive loss. Interventions indicated "7/7/13... Brush teeth and tongue at least twice a day...." The resident's Quarterly MDS (Minimum Data Set) Assessment dated 9/30/15, indicated the resident's personal Hygiene requirement was extensive assistance and one person physical assistance. On 12/3/15 at 10:15 a.m., the resident		**potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Dependent resident care plans and Kardex have beenupdated to address need for oral care and bathing/shower schedule. 2.CNAs have been re-educated regarding standard of carefor providing oral care and showers/baths schedule and care requirements,including completion of ADL documentation. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.ADNS/designee/MDS nurse will monitor/audit CNAsdocumentation practices and completion randomly on all shifts but at least 3times a week and report results to QAA committee and ADNS/designee. 1.Staff will be subject to 1:1 re-education and thenprogressive disciplinary action as indicated. 2.Administrator will be responsible to assign anyadditional action required. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	was observed with white debris along her bilateral gumline and upper and lower teeth and in between her teeth. On 12/3/15 at 2:32 p.m., the resident was observed visiting with her granddaughter. Her upper and lower teeth had white colored debris along the gumline and between her teeth. Her gums are reddened and inflamed. On 12/8/15 at 8:37 a.m., the resident was waiting in the assist dining room for her breakfast. She had white debris in between her upper and lower teeth and along bilateral gum lines. Her gums were reddened and inflamed. On 12/4/15 at 12:45 p.m., the Executive Director (ED) indicated he had no way to indicate that oral care had been completed for this resident. He indicated the CNA's documented dressing and grooming for ADL's, but they do not document when they did oral care. 2. On 12/03/15 at 10:56 a.m., the record review for Resident #87 was completed. Diagnoses included, but were not limited to, anoxic brain injury, heart attack, pressure ulcers, respiratory failure and neurogenic bladder. During an interview with a family member on 11/30/15 at 4:33 p.m., the		1.ADNS//designee/MDS nurse will monitor/audit CNAsdocumentation practices and completion 5 times per week for 1 month and then 3times per week for 1 month and report results to QAA. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	family member indicated the resident was not given a shower or bathed regularly. The residents Activities of Daily Living documentation indicated: Wednesdays and Saturdays were shower days. A bed bath was completed on 11/4, 11/11, 11/14, 11/18, 11/21, and 11/25/15 and 12/5/15. The Skin Worksheet documentation for showers was requested from August to December 2015. The documentation provided by the Quality Assurance Specialist(QAS) on 12/8/15 at 3:30 p.m., indicated the resident had received a bed bath on 8/2/15, 9/16/15, 9/26/15 and 10/28/15. The QAS indicated at that time it had been identified that documentation of ADL's was an issue. 3.1-38(a)(2)(A) 3.1-38(a)(3)(C)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure infection control practices were followed and failed to ensure interventions were implemented for 1 of 3 residents reviewed for pressure ulcers. (Resident #87) Findings include: On 12/03/15 at 10:56 a.m., the record review for Resident # 87 was completed. Diagnoses included, but were not limited to, anoxic brain injury, heart attack, pressure ulcers, respiratory failure and neurogenic bladder. The Admission assessment dated 6/19/15 indicated,"...coccyx area Stage 2 ulcer...." The Progress notes indicated: 6/23/15- The resident was admitted with one stage 2 pressure ulcer on his coccyx which measured 1 centimeter(cm) x 0.4 cm x 0.1 cm with minimal serous (clear body fluid) drainage. The wound bed had new epithelial (outer layer of skin) growth, and a foam dressing was in place. The resident was on an anti pressure mattress and the heels were floated. 6/30/15-The note indicated the resident	F 0314	**Corrective Actionsfor residents affected:** 1.Resident #87 is currently having his wound dressingchanged according to facility policy and infection control standards. Resident #87 has not experienced any adverseeffect as a result of this finding. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Residents with wound dressing changes could be affectedby inappropriate technique. 2.RN #2 has been re-educated 1:1 regarding policy forclean dressing change and use of gloves. 3.CNA #1 has been re-educated on following correctprocedure for provision of incontinence care. 4.Nursing staff has been educated on facility wounddressing change policy. 5.Staff has been educated on facility policy regardingsupport services being correctly operational when the resident is in bed.	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	was admitted with one stage 2 pressure ulcer on his coccyx and the wound measured 0.7 cm x 0.4 cm x 0.1 cm with minimal light red drainage. The wound bed had new epithelial growth and had a foam dressing in place. The resident was on an anti pressure mattress and the heels were floated. 7/7/15- The resident was admitted with one unstagable pressure ulcer on his coccyx. The wound measured 2.9 cm x 1.9 cm x 0.1 cm with minimal serous drainage. The wound bed was covered with slough (dead tissue) and with eschar (old dead tissue) in the middle of wound, there was a foam dressing in place. The resident was on an anti pressure mattress and the heels were floated. The resident was on a 2 hour turning and repositioning schedule. The Care Plan for skin dated 7/16/15 indicated, "...At risk for alteration in skin integrity related to: incontinence, impaired mobility, diabetes/PVSD, end stage disease...APM, barrier cream to peri area/buttocks as needed, diet and supplements per md order, encourage to reposition as needed; use assistive devices as needed, float heels as able, observe skin condition with ADL care daily; report irregularities, provide preventative skin care routinely and PRN, use pillows/positioning devices as		**What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.The ADNS/designee will observe licensed nursesproviding clean dressing changes. Theseobservations will be completed on all shifts each week for 4 weeks. Any nurse observed to use inappropriatetechnique will be counseled. 2.The ADNS/designee will observe CNAs providing pericareon all shifts weekly x 4 weeks then monthly. **How will correctedaction be monitored:** 1.ADNS/designee will continue to observe nurses providingclean dressing changes weekly on alternating shifts weekly x 4 weeks thenmonthly thereafter until substantial compliance has been achieved and reportfindings to QAA Committee. 2.ADNS/designee will continue to observe CNAs providingpericare weekly on alternating shifts x 4 weeks then monthly thereafter untilsubstantial compliance has been achieved and report findings to QAA Committee. Results of QA audits will be presented to QAA committee monthlyfor determination of need for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	needed...." The wound care clinic notes indicated: 8/10/15: ulcer coccyx wound measured 5.4 cm x 3.5 cm x 2 cm. ulcer right shoulder: 1.8 x 0.7 x 0.1 cm ulcer: left lateral foot/heel :3.5 cm x 2 cm x 0.1 cm 8/31/15: ulcer coccyx: 6 cm x 4.5 cm x 2.7 cm ulcer right shoulder: 1.5 cm x 0.5 cm x 0.1 cm ulcer left lateral foot/heel: 4 cm x 2.5 cm x 0.5 cm The wound care noted dated 11/18/15 indicated the pressure ulcer on the coccyx 7 cm x 3.6 cm x 0.3 cm ...hand written note indicated "...* continue pressure reduction measures!...elevating heels Turn/reposition frequently...." On 12/8/15 at 10:39 a.m., the Low Air Loss (LAL) Mattress was observed to be on standby (a position which the air mattress does not have as much inflation of air). On 12/8/15 at 10:50 a.m., the residents LAL mattress was observed to be on standby and RN #2 indicated the power should have been on and should have been set at "5" but sometimes shuts itself off. She would have maintenance look at		further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	it, as if the resident was out of bed for a period of time the bed sometimes shut itself off. CNA #1 indicated the resident had not been out of bed this morning as it takes two staff to get him out of bed. During an observation on 12/8/15 at 10:51 a.m., the resident had a bowel movement. CNA #1 had donned gloves and cleaned the resident off with moist wipes and then took gloves off and placed into the garbage. She then left the room to go and get wash clothes and a basin. At that time, RN # 2 had to push the call light as she had realized she had forgotten some of the wound supplies. RN #3 answered the call light. RN #2 pulled the privacy curtain back with her gloved hand and requested the wound supplies from RN #3. RN #3 left to get wound supplies and returned at 10:55 a.m. RN #2 then pulled the bedside table closer to her with her wound supplies on them. She requested for RN #3 to assist her in the wound dressing change. At that time, RN #3 took off the resident's coccyx dressing and the dressing was observed to have moderate amount of dark tan/ yellow exudate. The resident's coccyx area was observed to be open and beefy red in color. RN # 2 asked RN #3 to place a clean towel under the wound as the resident had just been cleaned off and there was smearing of bowel movement			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	on the sheet underneath. RN #2 measured the coccyx wound as 7 cm x 3 cm with undermining 2 cm at 6 o'clock. The tissue was all epithelial tissue and was a healing stage 4. The wound edges were indicated as intact not red. RN #2 touched with gloved hand the edges of the wound and the inside of the wound with gloved finger. She then took her bullet of normal saline which was placed on top of the packets of dressing and package of gauze and broke open the bullet of saline and squirted the saline from the bottom edge of the wound to the top edge of the wound. She then blotted the area with dry gauze. Then rinsed again with normal saline from the top of the wound to the bottom and blotted with dry gauze. RN #2 then with the same gloved hands opened the silver alginate packing and placed into wound and packed to wound with her gloved hands. RN #2 took the Allevyn dressing with same gloved hands and placed the Allevyn around wound. She indicated needed to change gloves again, took off her gloves and donned a new pair of gloves, without washing or sanitizing hands. During an interview on 12/08/15 at 11:28 a.m., RN #2 indicated she should have had a clean sheet for when the resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	had the bowel movement. She also indicated she was not aware that she had not washed her hands after touching various items in the room. She indicated should have cleaned with normal saline from top to bottom and the tunneled area first if there was one. On 12/9/15 at 1:40 p.m. the Executive Director provided the Dressing Change policy dated 12/2009. The policy indicated, "...PROCEDURE: 11. Remove latex free non sterile gloves and discard in trash bag perform hand hygiene. 13. Establish clean filed by covering beside table with paper towels or clean towel and if necessary establish a sterile field...14...clean pair of latex free non sterile gloves for non sterile gloves for non sterile dressing change. 15. Cleanse wound per physician's orders. 16. Remove gloves and perform hand hygiene. 17...Apply latex free non sterile gloves. 18. Apply dressings and secure per physician's orders...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to provide range of motion services and implement splint devices for 3 of 3 residents reviewed for range of motion. (Resident #4, Resident #70 and Resident #87) Findings include: 1. On 12/03/15 at 10:56 a.m., the record review for Resident # 87 was completed. Diagnoses included, but were not limited to, anoxic brain injury, heart attack, pressure ulcers, respiratory failure and neurogenic bladder. A document titled, "Therapy Follow Up Communication" indicated, "...Passive range of motion of upper and lower extremities during Activities of Daily Living...Splint Wear Apply splint to left and right wrist from 8:00 a.m.-5:00 p.m. daily and apply splint to left elbow from 5:00 p.m. to 8:00 p.m. daily...." During an observation on 11/30/15 at 10:15 a.m., the resident was observed in bed with no splints on, they were lying in his lap. During an interview on 11/30/15 at 3:59	F 0318	**What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** Resident 4 Range ofmotion is being provided per the plan of care. Resident 70: Range of motion and splints are being providedper the plan of care. Resident 87: Range ofmotion and splints are being provided per the plan of care. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken;** Residents that utilize brace/support devices and have ordersto receive range of motion have the potential to be affected by the samedeficient practice. The clinical records for residents with brace/supportdevices have been reviewed to ensure there are physician orders for use, andCare Plan updated The clinical records for residents with therapyrecommendations for range of motion have been reviewed to ensure their careplan and	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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.m., LPN #7 indicated Resident #87 had contractures of both arms and hands and that the aids usually put the splints on in the morning between 8 to 10 a.m. During an observation on 11/30/15 at 3:15 p.m., a sign was observed on the wall which indicated, "... black splint instructions (hand wrist) 1. Place on every morning 2. Take off every evening 5:00 p.m. Splints in pink holder in window...." The splints were not observed on and there was no pink holder in the window sill. During an observation on 12/04/15 at 9:57 a.m., the resident had a gray brace around his left arm/elbow area. There were no black splints observed to be on the resident at that time. During an observation on 12/08/15 at 11:34 a.m., the resident had gray left arm brace on and black splint devices were not observed to be on at that time. The treatment documentation for December 2015 indicated, "...apply splints to left and right wrist upper extremity every morning...." The time in the box indicated 8:00 a.m. The dates 12/1, 12/2, 12/3, 12/4, 12/5, 12/6, 12/7 and 12/8/15 had been checked that this task had been completed.		KARDEX is updated and reflects current recommendations. **What measures will beput into place or what systemic changes will be made to ensure that the samedeficient practice does not recur;** Licensed staff has been re-educated on need to ensure thatsplints are applied per the physician order and that range of motion isprovided per the plan of care. Certified Nursing Assistants have been re-educated onapplying and documenting the application of splints per the physician order andproviding range of motion per the plan of care. The Director of Care Delivery or designee will review thoseresidents with mobility assistive devices and orders for Range of motion dailyfive times a week, alternating days and shifts, to ensure the plan of care isfollowed. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur;i.e., what quality assurance program will be put into place;** Audit findings will be presented to the QA&A Committeeweekly for four weeks and monthly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	During an interview on 12/8/15 at 4:10 p.m., the Quality Assurance Specialist indicated the aides were to be doing the range of motion for Resident #87, but there was no documentation indicating it had been completed. 2. The record review of Resident #70 was completed on 12/08/2015 at 10:30 a.m. Diagnoses included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis. A quarterly MDS assessment, dated 11/10/2015, indicated Resident #70 had an impairment to functional range of motion on one side for upper and lower extremities. The resident participated in occupational therapy from 8/19/2015 to 10/07/2015. A therapy follow up note, dated 10/07/2015, indicated "...apply splint to right upper extremity at nite [sic]...Active-assisted ROM [range of motion] of upper extremities during ADLs [activities of daily living]...." During an interview on 12/09/2015 at 4:24 p.m., the Director of Rehab indicated Resident #70 had participated in physical an occupational therapy on and off since 2014. Her last round of occupational therapy ended 10/07/2015.		Ongoing monitoring will continuefor a minimum of six months. The QA&A Committee will review findings anddetermine the need for further monitoring and/or education per the QA&Aprocess	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	Resident #70 had right sided hemiplegia, with a flaccid right upper extremity. There was no active movement on Resident #70's right side, but the left side was within normal limits. Resident #70 wore a splint on the right hand at night for proper positioning and should have received standard range of motion daily with active assist, meaning the resident did as much as she could and staff assisted. During an interview on 12/02/2015 at 11:11 a.m., LPN #8 indicated Resident #70 did not receive range of motion services. During an interview on 12/09/15 at 2:08 p.m., Resident #70 indicated staff did not help her with range of motion. A care plan for range of motion could not be found within the clinical record of Resident #70. Range of motion activities were not listed on the kardex for CNA use. There was also no tracking available to indicated the facility had performed range of motion services. During an interview on 12/10/2015 at 3:34 p.m., the Quality Assurance Consultant indicated there was a care plan in place for range of motion and the splint device as of 12/10/2015 and the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	ROM had been added to the kardex and tasks list for CNA to track, however, these things were not in place prior to 12/10/2015.3. On 12/2/15 at 11:42 a.m., Resident #4's left arm was observed to be contracted. The resident indicated at that time she was not receiving ROM (Range of Motion) services for the contracture. During an interview on 12/2/15 at 10:56 a.m., LPN #14 indicated the resident had a contracture of her right arm, but she did not have any orders for ROM services at that time for her right arm. Resident #4's record was reviewed on 12/3/15 at 11:38 a.m., Diagnoses included, but were not limited to, multiple sclerosis, neuromuscular dysfunction and dysphagia. A Physical Therapy Evaluation and Plan of Treatment note dated 8/24/15, indicated right upper extremity (RUE) ROM-Impaired, left upper extremity (LUE)ROM-Impaired, left lower extremity (LLE) ROM- Impaired. An Admission MDS Assessment dated 8/28/15, indicated the resident had bilateral upper and lower extremity impairments. A "Therapy Follow up Communication"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	note dated 10/7/15, indicated Range of Motion/Movement Passive range of motion of the lower extremities during ADL's (Activity of Daily Living). A "Therapy Follow Up Communication" note dated 10/13/15, indicated Range of Motion/Movement Active-assisted range of motion of upper extremities during ADL's right, Passive range of motion of upper extremities during ADLS's left, Active range of motion of lower extremities during ADL's Passive range of motion of lower extremities during ADL's bilateral, Precautions (specify) LUE (Left Upper Extremity) slow stretch. During an interview on 12/10/15 3:30 p.m., Quality Assurance Specialist (QAS), the Executive Director and the Administrator was in attendance. The QAS indicated the facility did not have anything in place to identify the resident's ROM was being performed with ADL care. She indicated the Plan of Care (Kardex) was updated to reflect the ROM issues, so the ROM should be getting done now and the aides should be documenting it as they were suppose to be. 3.1-42(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to establish measures to prevent the elopement of a resident for 1 of 3 residents reviewed for accidents (Resident #8). The facility also failed to ensure 1 of 4 medication carts were kept locked and 3 of 4 storage areas were kept locked. Findings include: 1. The record review for Resident #8 was completed on 12/08/2015 at 9:30 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, depressive disorder, and non-organic psychosis. An Admission Minimum Data Set (MDS) assessment, dated 06/15/2015, indicated Resident #8 scored a 3 on the Brief Interview of Mental Status (BIMS), meaning the resident was severely cognitively impaired. It also indicated	F 0323	**What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?** Resident 8: No longer resides at the facility **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken;** Residents at risk for wandering and elopement have potentialto be affected by the same deficient practice. Upon admission and with change in condition residents willbe identified for wandering behavior which could result in elopement. The careplan will be updated to reflect appropriate interventions to reduce risk andincrease resident safety. Doors that are to be secured have been identified andsecured.	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	locomotion on and off of the unit required supervision, meaning the resident required oversight, encouragement, or cueing. Progress notes faxed to the facility from the referring psychiatric facility on 06/04/15 indicated the following: Physician Care Notes: 5/27/25: "...[Resident] did become somewhat disoriented last night and wandered the unit and went into an unlocked room and [urinated] in a wastebasket. Of course, this is indicative of his level of confusion more than anything else...." 6/1/15: "...[Resident] last night became very re-emphatic about the need to leave. He also became distressful and suspicious...." Nursing Reassessment Notes: 5/19/15: "...[Patient] wandering - questioning why he's here et [and] where his spouse is...." 5/20/15: "[Patient] wanders physically and mentally...." 5/24/15: "...Wanders a lot...." 5/29/15: "...Pacing the floors, wanders a lot...." 5/30/15: "...Wanders and paces a lot. Seems friendly and cooperative...." 5/31/15: "...[Patient] wanders often into		Medical records and electronic medical record devices havebeen secured. Medication carts are being secured to prevent unauthorizedaccess. **What measures will beput into place or what systemic changes will be made to ensure that the samedeficient practice does not recur;** Licensed Nursing staff and Certified Nursing Assistants havebeen re-educated on the Behavior Practice Guideline which includes wanderingand elopement process. Licensed Nursing staff has been re-educated on theMedication Administration Guidelines which includes securing medication carts. Licensed Nursing staff has been educated on MaintainingClinical Records which includes securing electronic medical records. Clinical and Non-clinical staff has been educated on doorsecurity. The Director of Care Delivery or designee will conduct observationsdaily five times a week, alternating days and shifts, to ensure staff are following interventionsfor residents identified as risk for wandering.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	others rooms...." 6/1/15: "...Patient wandering unit, confused...." A facility Nursing Admission Assessment, dated 6/4/14, indicated Resident #8 was cognitively impaired with mobility. The assessment indicated Resident #8 did not have a history of exit seeking or wandering. Facility Nursing Progress Notes indicated the following : 6/5/2015 12:41 a.m.: "...ambulatory independently but has history of wandering...." 06/05/2015 2:02 p.m.: "...[Resident] alert/oriented to self...[Resident] confused to place and time...[Resident] ambulates independently...[Resident] must be oriented and redirected often...." 06/06/2015 7:23 p.m.: "...CNA went to resident's room at 1600 [4:00 p.m.] and resident was not in his room. Staff started room to room checks. Checked bathrooms and behind doors and closets. CNA notified the MOD [Manager on Duty]. Sweep the premises. Received call from police at 1610 [4:10 p.m.] that resident was at [name of store]...."		The Director of Care Delivery or designee will conductobservations daily five times a week, alternating days and shifts, to ensure Ancillary and Supply rooms are secure. The Director of Care Delivery or designee will conductobservations daily five times a week, alternating days and shifts, toensure Medical records are maintained in a secure manner **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur;i.e., what quality assurance program will be put into place;** Audit findings will be presented to the QA&A Committeeweekly for 4 weeks and monthly thereafter. The QA&A Committee will reviewfindings and determine the need for further monitoring and/or education per theQA&A process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	A Social Services progress note, dated 06/06/2015 at 5:00 p.m., indicated "...admitted to facility on 6/4/15 from [name of psychiatric care center]. According to the notes from [name of psychiatric care center] pt. [patient] was admitted on 5/18/15 with reportedly increasing memory loss as well as some difficulty redirecting...Hospital notes also stated pt. became distressful and suspicious of staff during his stay...BIMS score 3 which indicates pt. has severe cognitive impairment...." An incident report submitted by the facility to the Indiana State Department of Health, dated 06/05/2015, provided by the Administrator on 12/08/2015 at 11:30 a.m., indicated the resident was given a drink of water at 2:50 p.m. At 4:00 p.m., resident was noticed missing from his room. The resident was returned to the facility at 4:15 p.m. and was moved to a secure unit. A wander guard device was applied. It was determined the resident followed a visitor out the door, but no time frame was established. During an interview on 12/10/15 at 3:03 p.m., the Social Services Director indicated The IDT (interdisciplinary team) team reviewed information prior to admission. Residents who were deemed to be wander and/or elopement risks			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	tended to go to the second floor because it was more secure. Resident #8 was placed on the first floor because he was going to be a short-term stay. If a resident had a previous history of wandering or documentation that they had tried to exit the healthcare door, the IDT team would determine the need for a wander guard. No behavior tracking for wandering, wander guard, careplan or initial plan of care was put in place for Resident #8 prior to the elopement incident on 06/06/2015. The facility evaluation of the wandering and elopement risk for Resident #8 was requested on 12/10/2015 at 3:30 p.m. The facility was unable to provide this information before the time of the survey exit on 12/10/2015 at 5:45 p.m. 2. On 12/08/15 at 8:38 a.m., the nurse's medication cart on the first floor was observed to be pushed up against the front of the nurse's station, unlocked. The computer was also observed to be unlocked, displaying resident information. RN #11 was observed behind the nurse's station and, when informed of the situation, came around and locked the cart and computer screen. RN #11 indicated it was not her cart, but both the computer and medication cart should be locked when not in use.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	On 12/10/2015 at 8:24 a.m., the nurse's medication cart on the first floor was observed to be pushed against the nurse's station, unlocked. No staff members were present. RN #12 came out of a resident's room and upon being told about the situation, locked the cart. RN # 12 indicated he was not working that particular cart, but it should have been locked. A current policy titled "Medication And Treatment Administration Guidelines," dated 12/2014, provided by the Quality Assurance Consultant on 12/10/2015 at 3:27 p.m., indicated "...Medication Storage And Security:...Medications and biological's are securely stored in a locked cabinet, cart or medication room...and maintained under a lock system when not actively utilized and attended to by nursing staff for medication administration...." 3. During an initial tour on 11/30/2015 at 10:20 a.m., a supply closet on the second floor was observed to be unlocked. The closet contained items including, but not limited to, razors, shaving cream, denture cleanser and lotion. A room on the second floor, labeled clean utility, was also observed to be propped open. The door had a sign that indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	it was to be kept locked and closed at all times and contained items including, but not limited to, nebulizers, urinary supplies, oxygen supplies, and a wheelchair. On 12/01/2015 at 3:07 p.m., a storage room door on the first floor was observed to be propped open. A sign on the door indicated it was to be kept locked and closed at all times. The room contained items including, but not limited to, razors, shampoo, bed pans, briefs, deodorant, manicure sticks, and nail clippers. On 12/10/2015 at 8:29 a.m., the storage room door on the first floor was again observed to be propped open. On 12/10/2015 at 9:55 a.m., the clean utility room on the second floor was again observed to be propped open. A box of hand sanitizer was visible from the doorway. During an interview on 12/10/2015 at 8:35 a.m., RN #12 indicated the storage room doors were almost always kept open. During an interview on 12/10/2015 at 3:30 p.m., the Quality Assurance Consultant indicated there was not a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	corporate policy regarding the storage rooms, but they followed state regulations. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to monitor side effects and adverse consequences of psychotropic medications for 2 of 5 residents reviewed for unnecessary	F 0329	**Corrective Actionsfor residents affected:** 1.Resident # 116 and #120 have not experienced any sideeffects of medication use. 2.The care plans for Resident	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	medications (Resident #116 and Resident #120). 1. The record review for Resident #120 was completed on 12/08/2015 at 2:15 p.m. Diagnoses included, but were not limited to, depressive episodes and anxiety. Physician Orders were as follows: 11/5/2015 - Temazepam (a hypnotic medication) - 15 mg (milligrams), Give 1 capsule by mouth as needed for insomnia at bedtime. 11/5/2015 - Xanax (an antianxiety medication) - 0.5 mg, Give 1 tablet by mouth every 6 hours as needed for anxiety 11/5/2015 - Escitalopram Oxalate (an anti-depressant)- 20 mg, Give 1 tablet by mouth once a day for depression (discontinued 11/15/2015) 11/15/2015 - Escitalopram Oxalate Tablet 10 mg, Give 1 tablet by mouth once a day for depression for 2 Weeks (discontinued 11/16/2015) 11/15/2015 - Venlafaxine Hcl (an anti-depressant medication) - 37.5 mg, Give 1 tablet by mouth three times a day for depression 11/16/2015 - Citalopram HBR (an anti-depressant medication) - 20 mg, Take 1 tablet by mouth 1 time a day for depression		#116 and Resident #120 havebeen updated to include the intervention to monitor for side effects. 3.Resident #120 now contains documentation of side effectmonitoring. 4.The care plans for residents requiring psychoactivemeds have been updated to include the intervention to monitor for side effects. 5.The MAR's (Medication Administration Record) for residentsreceiving psychoactive meds now includes documentation of monitoring sideeffects. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Residents requiring psychoactive meds in the facilityhave the potential to be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.Nurses will be inserviced on the proper documentationof side effect monitoring on the MAR's. **How the correctiveaction(s) will be monitored to ensure the deficient**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	A medication administration record (MAR), dated November 2015, indicated Resident #120 was administered the anti-depressant medication as prescribed. Resident #120 was also administered Temazepam on November 12, 14, 15, and 18, 2015 and was administered Xanax on November 13, 2015. No monitoring of medication side effects could be found in the resident's clinical record. During an interview on 12/10/15 at 3:03 p.m., the Social Services Director indicated residents that had a psychotropic medication should have had a psychotropic medication care plan and an order to monitor side effects on the medication administration record where staff can monitor daily. During an interview on 12/10/2015 at 4:27 p.m., the Quality Assurance Consultant indicated there was no adverse consequence or side effect monitoring for psychotropic medication prior to 12/10/2015. 2. The record review for Resident #116 was completed 12/08/2015 at 11:45 a.m. Diagnoses included, but were not limited to, anxiety, depression and dementia		**practice will not recur:** 1.The Administrative Director of Nursing and Director ofCare Delivery will be responsible to review documentation of side effect mentoring5 days a week for 4 weeks, then weekly thereafter. The Administrative Director of Nursing/designeewill be responsible to verify that the care plan intervention for monitoringside effects is entered for each resident receiving psychoactive meds. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	without behavioral disturbance. A Physician's Order, dated 11/25/15, indicated Zoloft 25 mg daily for depression. No monitoring of medication side effects could be found in the resident's clinical record. During an interview on 12/10/2015 at 4:27 p.m., the Quality Assurance Consultant indicated there had been no monitoring of adverse consequences or side effects for psychotropic medications before 12/10/2015. A behavior practice guide, dated 07/2015, provided by the Quality Assurance Consultant on 12/10/15 at 4:25 p.m., indicated "...Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:...(iii) Without adequate monitoring...(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued...." 3.1-48(a)(3)			
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview and record review, the facility failed to properly post nurse staffing information. This deficient practice had the potential to affect 62 of 62 residents residing in the facility. Findings include:	F 0356	**Corrective Actionsfor residents affected:** 1.The facility staffing was immediately posted correctlyand has been posted correctly every day since. **How other residentshaving the**	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	During an initial tour on 11/30/2015 at 10:15 a.m., the nurse staffing data was not visible on the first or second floor. During an interview on 11/30/2015 at 1:28 p.m., CNA #13 indicated staffing information was posted every evening for the following day. Staffing information was placed in the daily staffing binder. During an interview on 11/30/2015 at 3:31 p.m., RN #11 indicated the daily nurse staffing information used to be displayed at the nurse's station, but she had not seen the appropriate daily staffing sheet in approximately a month. The Daily Staffing Binder was reviewed on 11/30/2015 at 3:35 p.m. Each sheet had the nursing staff names listed as scheduled, but did not list the facility census or total number and actual hours worked by licensed and unlicensed personnel. The staffing sheets were also not in a clear and readable format. The sheets contained staff names that had been scratched out due to call-offs, with replacement staff names handwritten beside the original names. The staffing sheet for 11/30/2015 was located in the staffing binder and was not displayed prominently nor readily accessible to residents and visitors.		**potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Residents in the facility have the potential to beaffected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.The Facility Staffing is posted daily in a prominent placevisible to the public. There was noadverse effect to any resident as a result of this error. 2.The Staffing Coordinator has been re-educated regardingcompleting, posting and updating the facility staffing document. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:** 1.The Administrator or designee will verify byobservation each week that the posting is completed and posted correctly, andwill report all findings to QAA committee. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	During an interview on 12/10/2015 at 3:38 p.m., the Quality Assurance Consultant indicated there was not a specific facility policy related to nurse staffing information, but the facility followed Indiana State guidelines.			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure proper food storage, kitchen appliances were kept clean and failed to ensure pans were stored under sanitary conditions. This deficient practice had the potential to affect 57 of 62 residents receiving food from the kitchen. Findings include: The kitchen tour started on 11/30/15 at 10:16 a.m., with the Food Service Director (FSD) in attendance. 1. The grill top oven had black burnt debris on the sides and bottom of the oven and the door of the oven. The FSD	F 0371	**Corrective Actionsfor residents affected:** 1.Items listed 1-5 have been thoroughly cleaned. 2.Item 6 Dented cans were removed the first day of thesurvey and were sent back to the vendor for credit. 3.Item 7: Itemsthat were not thoroughly dried were re-washed and allowed to air dry properlyprior to any use. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Residents in the facility have the potential to beaffected. **What measures will beput into place or what systemic**	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	indicated the grill top oven had not been cleaned for a couple of weeks. 2. The grill had burnt on brown substance. The FSD indicated at that time the brown substance was from the butter the cooks used that morning to cook the breakfast with. She indicated the grill got wiped down daily. 3. The stove top oven had aluminum foil with a brown burnt on debris on it and the sides and the door of the oven had a brown burnt on debris on them. The FSD indicated the foil should be changed every night and it could not have been changed last night. The food catch drawers on the stove top oven had black burnt on debris, french fries, potato wedges and other food debris in the drawer. The FSD indicated at that time she did not know when the food catch drawers were cleaned last, but they should have foil in the bottom and be cleaned everyday. 4. The range top had burnt on black debris around burners. The FSD indicated some of the burnt on debris will come off, but not all of it. 5. The convection oven had burnt on black debris both sides and the bottom of the oven. The FSD indicated the oven		**changes will be made to ensure that thedeficient practice does not recur:** 1.Dietary staff will be re-educated on the properprocedure for cleaning, including when, how and who is responsible for thecleaning. 2.Cleaning schedules, including daily, weekly andmonthly, will be updated and the dietary staff re-educated on implementation. 1.Dietary staff will be re-educated on what to do withdented cans, if received from a vendor. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:** 1.The Food Services Director or designee will audit allequipment for cleanliness daily for 4 weeks and then 3 times weekly for 4 weeksand report all findings to QAA committee. 2.The Food Services Director or designee will auditstorage unit for dented cans daily for 4 weeks then 3 times weekly for 4 weeksand report all findings to QAA committee. 3.The Food Services Director or designee will auditdishwashing techniques to ensure proper drying of all pots, pans, utensils,etc. prior to being placed in service for use. 4.Administrator will be responsible to assign anyadditional action required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	was cleaned last week, but she did not know if it was signed off on the cleaning list or not. 6. The following cans were observed dented on the shelves: 1-6 lb (pound) 8 oz (ounce) can of apple slices 1-6 lb 9 oz can of mandarin oranges 4-7 lbs 5 oz cans of butterscotch pudding 1-7 lb 5 oz can of cranberry sauce 1-6 lb 12 oz can of applesauce 2-6 lb 8 oz cans fruit cocktail 1-50 oz can cream of mushroom soup During an interview at that time, the FSD indicated she sent the dented cans back to the company. She indicated she was not here on Friday when the supplies were put up, so that was why these dented cans were on the shelves. 7. The following pans and containers were identified by the FSD as having water between them and running down the pans and containers as follows: 3-tall square plastic containers with water beads between them, which ran down the containers when the top container was lifted off the container below it. 2-short plastic containers with water beads between them, which ran down the		5.The Food Services Director or designee will monitorcompletion of cleaning schedules 5 times a week for 1 month then 3 times a weekfor 1 month, then as needed. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	containers when the top container was lifted off the container below it. 3-large square plastic containers with water beads between them, which ran down the containers when the top container was lifted off the container below it. 3-rectangular shaped shallow metal pans with water beads on top of the first and second pans, which when the top one was lifted the water ran down onto the other pans and the shelf. 3-rectangular shaped deep metal pans with water beads on top of the first and second pans, which when the top one was lifted the water ran down onto the other pans and the shelf. 2-square shaped metal pans with water beads on top of the first pan and when the first pan was lifted the water ran down onto the second pan and the shelf. During that time the FSD indicated water was between the pans and containers and they should have been allowed to dry before being put onto the shelf. During an interview on 11/30/15 at 11:40 a.m., the FSD indicated she did not have any weekly cleaning schedule, which had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	been dated that was signed off since 9/28/15. She indicated she had one evening cook who does his cleaning daily faithfully. A "Weekly Cleaning Schedule" dated 9/28/15, provided by the FSD on 11/30/15 at 12:10 p.m., indicated the Ingredient Bins, in dry storage was the only area documented that was cleaned on the form. She indicated at that time, this was her most recent cleaning schedule she could find. A current policy titled "Receiving" dated September 2014, provided by the Executive Director on 12/4/15 at 3:00 p.m., indicated "...Guidelines...10. Check for dented canned items...." 3.1-21(i)(1)			
F 0406 SS=D Bldg. 00	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on interview and record review, the facility failed to ensure a resident obtained psychiatric services in a timely manner following a Psychiatric hospitalization for 1 of 1 residents reviewed for Pre-Admission Screening and Resident Review (PASRR). (Resident #7) Findings include: Resident #7's record was reviewed on 12/8/15 on 11:04 a.m. Diagnoses included, but were not limited to, bipolar disorder, unspecified mood disorder, major depressive disorder, anxiety disorder and insomnia. A "State of Indiana Certification of PASARR/MI [Pre-Admission Screening and Resident Review/Mental Health]" dated 3/31/14, indicated the evaluation was completed on 3/27/14. The Pre-Admission Screening Determination indicated the resident is mentally ill, but does not require specialized services. The Level II diagnoses were mood disorder and anxiety disorder. The resident was to receive services of less	F 0406	**Corrective Actionsfor residents affected:** Resident #7 is currently receiving thenecessary Psychiatric Services per recommendations. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.The Social Services Director has been re-educated byAdministrator follow up to ensure Psychiatric Services are being provided. In the event that Psychiatric Service cannot be provided within thefacility, the Social Services Director will arrange for outpatient PsychiatricServices are provided. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.Residents with diagnosis of mental illness including“Depression” have been reviewed by the Social Services Director to ensure theyare	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	intensity than specialized services, which were yearly resident review, psychiatric evaluation, individual therapy, medication review, medication monitoring and medication administration. A "Comprehensive Psychiatric Evaluation" from (name of hospital) dated 6/15/15, indicated the resident's chief complaint was worsening depression. A Social Service note dated 8/10/15 at 2:35 p.m., indicated the resident had some episodes of insomnia and was prescribed Trazodone. A Social Service note dated 8/24/15 at 12:36 p.m., indicated the resident had a PHQ-9 (Patient Health Questionnaire) was a 10, which indicated the potential for moderate depression. She indicated she had not been feeling well due to a cough and chest congestion and preferred to stay in her room. She indicated she did not want to participate in any activities at that time because she was not in the "mood" because of her cough. A Social Service note dated 9/24/15 at 12:00 p.m., indicated the resident indicated she mainly felt nervous and anxious during ADL (Activities of Daily		receiving Psychiatric Services. 1.Care Plans have been updated to reflect the resident isreceiving Psychiatric Services. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:** 1.Social Services Director will review/audit weekly x 4weeks and then monthly and report all findings to QAA committee. 2.Administrator will be responsible to assign anyadditional action required. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	Living) care and when the staff was using the lift to transfer her. A Social Service note dated 10/29/15 at 1:35 p.m., indicated the resident was going to yell out during transfers due to this was one of the main causes of her anxiety. A Social Service note dated 11/6/15 at 4:40 p.m., indicated the resident sought out the Social Service Assistant to indicate she felt her depression and anxiety was worsening. A Social Service note dated 11/9/15 at 3:50 p.m., indicated the resident's anxiety continued to occur during transfers and care. A Social Service note dated 11/12/15 at 5:05 p.m., indicated the resident was referred to (name of the Psychiatry group) for psychological/mental health evaluation and treatment. A (name of Psychiatric facility) note dated 11/25/15, indicated in the new or ongoing active signs and symptoms/concerns noted by staff: the resident got upset at staff easily, ruminating thoughts about broken relationship with a family member and giving the loss of her independence and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	her home. Under the Summary of Session the noted indicated the resident was very talkative, tearful at times, very eager to start therapy and "find relief." The resident indicated "just knowing you're coming makes me feel better." The note indicated she was experiencing insomnia and daily anxiety exacerbations. A (name of Psychiatric facility) note dated 12/9/15, indicated in the new or ongoing active signs and symptoms/concerns noted by staff: the resident has complaints, gets upset easily with staff, feels a loss of control, has depressive episodes and high anxiety. Under the Specific Interventions and Patient Responses the resident indicated the scheduled Xanax seemed to have helped with her anxiety because she no longer had to "ask and wait," which created more anxiety for her. During an interview on 12/10/15 at 3:03 p.m., the Social Services Director indicated the Resident #7 was on PASSR for Psychiatric services, but the facility could not get a Psychiatrist to come to the facility. She indicated the Psychiatric company she had coming to the facility had stopped coming because there were not enough residents in the facility for them to visit. She indicated after the resident was hospitalized and the Nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	Practitioner was monitoring her medications and as far as the Psychologist went, the resident only had the SSD to talk to about her psychiatric concerns. She indicated the resident did not get the Psychiatric services she should have had after her hospitalization until November because no one would come to the facility. She indicated she only had "me" when asked if any outside Psychiatric facilities were looked into for Psychiatric services after her hospitalization. 3.1-23(a)(1)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to remove gloves and handwash or sanitize hands after care for 1 of 1 residents. (Resident #87) Findings include: During an observation on 12/8/15 at 10: 50 a.m., the resident had a bowel movement. CNA #1 had donned gloves and cleaned the resident off with moist wipes and then took gloves off and placed into the garbage. She then left the room to go and get wash clothes and a	F 0441	**Corrective Actionsfor residents affected:** 1.Resident #87 is currently being cared for according tofacility policy and infection control standards. Resident #87 has not experienced any adverseeffect as a result of this finding. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Residents requiring incontinent care have the	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	basin on 12/8/15 at 10:55 a.m. She had not washed her hands before touching the doorknob to the room and walking out into the hallway. During an interview on 12/08/15 at 10:59 a.m., RN #2 indicated CNA #1 should have washed hands after cleaning up bowel movement and before she walked out of the door. During an observation on 12/8/15 at 11:05 a.m., RN #3 took off the resident coccyx dressing and threw into the garbage. She assisted RN #2 in turning and repositioning resident during wound care. RN #3 assisted in using moist wipes to clean off more bowel movement the resident had. She removed the gloves and then donned new gloves without washing hands. RN #2 and RN #3 had taken off soiled linen and had made the residents bed with clean linens after removing gloves as well as without washing hands. RN #3 took moist wipes and wiped off the residents face and neck without gloves on and without washing her hands. During an interview on 12/08/15 at 11:28 a.m. RN #2 indicated she should have washed her hands after changing the dressing and helping cleaning up the resident's bowel movement before		potentialto be affected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.Nursing staff has been re-educated regardingappropriate use of gloves, incontinent care and hand washing. 2.Nurses have been re-educated on following theappropriate technique for clean dressing change and use of gloves. **How will correctedaction be monitored:** 1.ADNS/designee will observe CNA's and nurses providingincontinent care on all three shifts each week for 4 weeks. 2.The Administrative Director of Nursing or designee willobserve all nurses provide clean dressing changes. These observations will be done on all shiftseach week for 4 weeks. Results of QA audits will be presented to QAAcommittee monthly for determination of need for further education or correctiveaction to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	changing the sheets. 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licesure Survey. Residential Census: 88 Sample: 7 The following residential findings were cited in accordane with 410 IAC 16.2-5.	R 0000	**This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparations and execution of this response and 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. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.**	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation and interview, the facility failed to ensure hallway ceiling tiles were without brown water spots and walls were without torn and marred walls for 2 of 2 floors observed. (3rd and 4th floor) Findings include: During a tour of the environment on 12/8/15 at 1 p.m., the following was observed: 3rd floor: Brown water spots, plate to saucer size on ceiling tiles on 3B by the janitor closet and between B304 and B305 Torn and marred walls and wallpaper between D304-D305, at entry of room	R 0148	It is the practice of this facility to comply with R148, Sanitation and Safety Standards **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The ceiling tiles identified on 12/8/15 have been replaced. The wallpaper identified on 12/8/15 has been repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** Residents who reside in this facility have the potential to be affected by this alleged finding. **What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur?** Housekeeping and Maintenance	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	D304 and D303 and at the entry to the trash room by the elevator. 4th floor: Brown water spots on the ceiling tiles on B hall in the lounge area, between B401-B402, and between B405-406 Window at end of D hall had torn wallpaper on the right side of the window frame. C-hall had a broken ceiling tile outside the janitor closet. During an interview with the Executive Director on 12/8/15 at 2 p.m., he indicated he was unaware of these environmental concerns.		Staff will be educated on the guidelines set forth in the Residential Regulations for this deficiency which includes identifying and correcting broken or water spotted ceiling tiles and torn or matted wallpaper. Staff who fails to comply with expectations for this regulation will be educated and or progressively disciplined as indicated. **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?** Maintenance Director/designee will complete weekly audits for three months to ensure there are not broken or water spotted ceiling tiles or torn and matted wallpaper. Areas that are found to have broken or water spotted ceiling tiles or torn and matted wallpaper, will be corrected immediately. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.	
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
Bldg. 00	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure Service Plans were signed by the Resident or Responsible party for 2 of 7 resident's reviewed for Service plan signatures. (Resident #508 and #623) Findings include: 1. The record for Resident # 508 was	R 0217	It is the practice of this facility to comply with R217, Evaluation; Service Agreement Addendum **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident's #508 and #623 has had the Service Plan Agreement Addendum signed. **How other residents having the potential to be affected by the**	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	reviewed on 12/8/15 at 10:30 a.m. A completed Service Plan dated 9./22/15 was unsigned by the resident or Responsible Party. 2. The record for Resident # 623 was reviewed on 12/8/15 at 11 a.m. A completed Service Plan dated 9/15 was unsigned by the resident or Responsible Party. The Service Plan had a note on it that indicated the family was called on 9/4/15 for signature on next visit. No other follow- up was noted. During an interview on 12/8/15 at 11:25 a.m., with the Wellness Director, she indicated she tried to contact the Responsible Party when the Service Plan was completed for a signature. She indicated she had not attempted to have the resident sign the Service Plan.		**same deficient practice will be identified and what corrective actions(s) will be taken?** Residents who reside in this facility have the potential to be affected by this alleged finding. **What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur?** We will review clinical records and ensure residents and/or their responsible party has signed the Service Plan Agreement Addendum. We will educate Nursing Staff to recognize the need for the Service Plan Agreement Addendums to be signed by the resident and/or the responsible party for residents who are provided additional services after their initial Service Agreement. Nursing Staff, who fail to comply with ensuring the Service Plan Agreement Addendums are signed, will be educated and or progressively disciplined as indicated. **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?** Wellness Director/designee will monitor and review the Service Plan Agreement Addendums weekly for 8 weeks to ensure residents and/or the responsible party is signing the Service Plan Agreement Addendums after they have been completed. Results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
			of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure proper food storage, kitchen appliances were kept clean and failed to ensure pans were stored under sanitary conditions. This deficient practice had the potential to affect 88 of 88 residents receiving food from the kitchen. Findings include: The kitchen tour started on 11/30/15 at 10:16 a.m., with the Food Service Director (FSD) in attendance. 1. The grill top oven had black burnt debris on the sides and bottom of the	R 0273	**Corrective Actionsfor residents affected:** 1.Items listed 1-5 have been thoroughly cleaned. 2.Item 6 Dented cans were removed the first day of thesurvey and were sent back to the vendor for credit. 3.Item 7: Itemsthat were not thoroughly dried were re-washed and allowed to air dry properlyprior to any use. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken:** 1.Residents in the facility have	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	oven and the door of the oven. The FSD indicated the grill top oven had not been cleaned for a couple of weeks. 2. The grill had burnt on brown substance. The FSD indicated at that time the brown substance was from the butter the cooks used that morning to cook the breakfast with. She indicated the grill got wiped down daily. 3. The stove top oven had aluminum foil with a brown burnt on debris on it and the sides and the door of the oven had a brown burnt on debris on them. The FSD indicated the foil should be changed every night and it could not have been changed last night. The food catch drawers on the stove top oven had black burnt on debris, french fries, potato wedges and other food debris in the drawer. The FSD indicated at that time she did not know when the food catch drawers were cleaned last, but they should have foil in the bottom and be cleaned everyday. 4. The range top had burnt on black debris around burners. The FSD indicated some of the burnt on debris will come off, but not all of it. 5. The convection oven had burnt on black debris both sides and the bottom of		the potential to beaffected. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** 1.Dietary staff will be re-educated on the properprocedure for cleaning, including when, how and who is responsible for thecleaning. 2.Cleaning schedules, including daily, weekly andmonthly, will be updated and the dietary staff re-educated on implementation. 1.Dietary staff will be re-educated on what to do withdented cans, if received from a vendor. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur:** 1.The Food Services Director or designee will audit allequipment for cleanliness daily for 4 weeks and then 3 times weekly for 4 weeksand report all findings to QAA committee. 2.The Food Services Director or designee will auditstorage unit for dented cans daily for 4 weeks then 3 times weekly for 4 weeksand report all findings to QAA committee. 3.The Food Services Director or designee will auditdishwashing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	the oven. The FSD indicated the oven was cleaned last week, but she did not know if it was signed off on the cleaning list or not. 6. The following cans were observed dented on the shelves: 1-6 lb (pound) 8 oz (ounce) can of apple slices 1-6 lb 9 oz can of mandarin oranges 4-7 lbs 5 oz cans of butterscotch pudding 1-7 lb 5 oz can of cranberry sauce 1-6 lb 12 oz can of applesauce 2-6 lb 8 oz cans fruit cocktail 1-50 oz can cream of mushroom soup During an interview at that time, the FSD indicated she sent the dented cans back to the company. She indicated she was not here on Friday when the supplies were put up, so that was why these dented cans were on the shelves. 7. The following pans and containers were identified by the FSD as having water between them and running down the pans and containers as follows: 3-tall square plastic containers with water beads between them, which ran down the containers when the top container was lifted off the container below it. 2-short plastic containers with water		techniques to ensure proper drying of all pots, pans, utensils,etc. prior to being placed in service for use. 4.Administrator will be responsible to assign anyadditional action required. 5.The Food Services Director or designee will monitorcompletion of cleaning schedules 5 times a week for 1 month then 3 times a weekfor 1 month, then as needed. Results of QA audits will be presented to QAA committee monthlyfor determination of need for further education or corrective action to ensurecompliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	beads between them, which ran down the containers when the top container was lifted off the container below it. 3-large square plastic containers with water beads between them, which ran down the containers when the top container was lifted off the container below it. 3-rectangular shaped shallow metal pans with water beads on top of the first and second pans, which when the top one was lifted the water ran down onto the other pans and the shelf. 3-rectangular shaped deep metal pans with water beads on top of the first and second pans, which when the top one was lifted the water ran down onto the other pans and the shelf. 2-square shaped metal pans with water beads on top of the first pan and when the first pan was lifted the water ran down onto the second pan and the shelf. During that time the FSD indicated water was between the pans and containers and they should have been allowed to dry before being put onto the shelf. During an interview on 11/30/15 at 11:40 a.m., the FSD indicated she did not have			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	any weekly cleaning schedule, which had been dated that was signed off since 9/28/15. She indicated she had one evening cook who does his cleaning daily faithfully. A "Weekly Cleaning Schedule" dated 9/28/15, provided by the FSD on 11/30/15 at 12:10 p.m., indicated the Ingredient Bins, in dry storage was the only area documented that was cleaned on the form. She indicated at that time, this was her most recent cleaning schedule she could find. A current policy titled "Receiving" dated September 2014, provided by the Executive Director on 12/4/15 at 3:00 p.m., indicated "...Guidelines...10. Check for dented canned items...."			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure Tuberculin Testing (TB) was completed on admission to the facility for 2 of 5 residents reviewed for TB testing. (Resident # 506a and #508) Findings include: 1. The record for Resident #506a was reviewed on 12/8/15 at 10 a.m. The resident was admitted in July 2015 and there was not a completed 1st or 2nd step TB test the record. During interview on 12/8/15 at 1:45 p.m., the Wellness Director indicated she could not locate any TB tests for this resident. 2. The record for Resident #508 was reviewed on 12/8/15 at 10:30 a.m. The resident was admitted to the facility from the facility's Health Care unit in August 2015. The resident had one	R 0410	It is the practice of this facility to comply with R410, Infection Control - Tuberculin Testing **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A Two-step Mantoux test has been initiated, per physician orders, for resident #506a and #508. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** Residents who reside in this facility have the potential to be affected by this alleged finding. **What measures will be put into place of what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing Staff will be educated on the guidelines for Tuberculosis Screening. Staff who fails to comply with expectations for this regulation will be educated and or progressively disciplined as indicated. **How the corrective**	01/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 00 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	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
	documented TB test on 6/1/15 without a documented 2nd step. During interview on 12/8/15 at 10:50 p.m., the Wellness Director indicated this was the only TB test she could locate for the resident. A policy titled "Tuberculosis Screening was received from the Executive Director on 12/9/15 at 11:20 a.m. The policy indicated "...Patient Screening Guidelines A Two-step Mantoux [TB] test is administered, per physician orders, to patients within 24 hours of admission...Step-1 is given prior to or upon admission...Step-2 is administered 1-3 weeks after reading the 1st step...."		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** Wellness Director/designee will complete weekly audits for three months to ensure residents admitted to assisted living have had and completed their two-step Mantoux test per center guidelines. Results of the monitoring will be reviewed for patterns/trends monthly by Executive Director/designee. Any non-compliance identified will be addressed with a Plan of Action to be reviewed weekly by the Executive Director/designee until compliance is achieved. Quality Assessment and Assurance Committee will review for ongoing compliance and accept and/or make recommendations monthly ongoing.	