STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395199	A. BUILDING _____ B. WING _____	**10/06/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-LANCASTER	**100 ABBEYVILLE ROAD LANCASTER, PA 17603**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interview, it was determined that the facility failed to develop a plan of care based on a resident's assessed needs for three out of 5 residents reviewed (Residents R1, R2 and R5). Findings include: Review of Resident R1's [DIAGNOSES REDACTED]. Review of Resident R1's quarterly MDS assessment (Minimum Data Set: MDS, a periodic assessment of resident care needs) dated August 4, 2017, revealed that the resident required the extensive assistance of two persons for bed mobility. The resident's BIMS (Brief Interview For Mental Status- determined cognitive function) was scored at a 4 indicating severe cognitive function. Review of Resident R1's care plan revealed that the facility failed to develop a care plan for bed mobility. The facility was asked to provide the resident's kardex (plan of care which provides specific directions to the nursing assistants in regard to the level of care needed by a resident). The facility was not able to provide the resident's kardex for review. Review of Resident R2's [DIAGNOSES REDACTED]. Review of the resident's quarterly MDS dated [DATE], revealed that the resident required the extensive assistance of two persons for bed mobility. Review of this resident's care plan failed to reveal direction for staff relating to bed mobility. Review of Resident R5's quarterly MDS assessment dated [DATE], revealed that the resident required the extensive assistance of one person for bed mobility and extensive assistance of two persons for transfers. Review of the resident's care plan revealed that there was no care plan developed for bed mobility and staff assistance required. Review of the resident's kardex indicated that the resident required one person for transfers and not two persons as indicated in the resident's assessment. An interview conducted with a day shift Registered Nurse (RN) Supervisor, Employee E6, on October 6, 2017, at 2:50 p.m. revealed that the nurses were responsible for the development of residents' care plans and that sometimes the nursing staff would reassess the resident's Activities of Daily Living (bed mobility, transfer, ambulation, eating, toileting, hygiene and bathing) or would receive a change suggested from the therapy department. These findings were discussed with the Nursing Home Administrator on October 6, 2017, at 2:30 p.m. The facility failed to develop resident care plans for bed mobility and/or transfers that reflected the assessed level of assistance required for safe transfers and bed mobility for Residents R1, R2 and R5. 42 CFR 483.20(d); 483.21(b)(1) Develop Comprehensive Care Plans Previously cited 09/29/17, 10/11/16 (At 42 CFR 483.20(d); 483.20(k)(1)) 28 Pa. Code 211.5(f) Clinical records Previously cited 09/29/17, 04/19/17, 03/06/17, 12/21/16, 10/11/16 28 Pa. Code 211.11(c)(d) Resident care plan 28 Pa Code 211.12(c)(d)(1)(5) Nursing services Previously cited 09/29/17, 09/15/17, 04/19/17, 03/06/17, 12/21/16, 10/11/16
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews with staff and review of facility policy, it was determined that the facility failed to provide the proper level of assistance during provision of incontinence care to one resident to ensure resident safety which resulted in the resident sustaining a fall from bed resulting in a hematoma to the head and was transferred to the hospital with a [DIAGNOSES REDACTED]. Findings include: Review of facility policy titled, Bed Positioning, reviewed 10/2011, for positioning residents for procedures revealed that turning a resident from back to side, the caregiver should, place one hand behind the shoulder of the resident and the other behind the hip and gently roll the resident toward the caregiver. To position a resident from side to back, place one hand behind the shoulder and the other behind the hip and gently roll the patient away from you until they rest on their back. Review of Resident R1's [DIAGNOSES REDACTED]. Review of the September 2017 physician's orders [REDACTED]. Review of Resident R1's quarterly MDS assessment (Minimum Data Set: MDS, a periodic assessment of resident care needs) dated August 4, 2017, revealed that the resident required the extensive assistance of two persons for bed mobility. The resident's BIMS (Brief Interview For Mental Status- determined cognitive function) was scored at a 4 which indicated severe cognitive function. Review of Resident R1's nursing note dated September 30, 2017, at 1:30 a.m. by the Registered Nurse (RN) Supervisor, Employee E3, revealed that she was called to the resident's room and found the resident on the floor on her left side with her head under a chair. The staff relayed to the nurse that the resident rolled off the bed while care was being provided. The resident stated that her head hurt and a large raised hematoma (collection of blood) was noted above the left temple. Review of the nursing note dated September 30, 2017, which was documented by Employee E3 revealed that the physician/nurse practitioner group was notified of the resident's fall. A physician's orders [REDACTED]. Review of hospital records dated October 2, 2017, revealed that the resident was admitted to the hospital on September 30, 2017 with a [DIAGNOSES REDACTED]. Review of Resident R1's care plan did not address the assistance needed for bed mobility. The resident's kardex (a care plan used by the nursing assistants for directing care) was not available for review since the resident was discharged from the facility. An interview was conducted on October 6, 2017, at approximately 10:40 a.m. with Nursing Assistant, Employee E4, the nursing assistant who provided care to Resident R1. She revealed that she was washing and changing the bed secondary to incontinence. She further stated that she was tucking the sheet under the resident with one hand holding her over and away from her and the other tucking the sheets when the resident suddenly fell off the bed head first. Employee E4 stated during interview that Resident R1 required one person for care which could not be confirmed with the resident's kardex.

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

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

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) An interview conducted on October 6, 2017, at approximately 10:30 a.m. with Employee E5, Nursing Assistant, revealed that she was passing ice water and assisting with rounds. When she entered the room and almost reached the bottom of the bed, she observed Nursing Assistant, Employee E4, providing care to Resident R1. She further stated that suddenly the resident was falling out of the bed and she could not get to the resident in time to stop the fall. The facility failed to ensure that Resident R1 was properly positioned and safely turned in bed during incontinence care which resulted in actual harm with Resident R1 sustaining a fall, hematoma to the head and being transferred to hospital with the [DIAGNOSES REDACTED]. 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 09/15/17, 03/06/17, 01/28/17 28 Pa. Code 201.18(a) Management 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management Previously cited 09/15/17, 03/06/17 28 Pa. code 211.5(f) Clinical records Previously cited 09/29/17, 04/19/17, 03/06/17, 12/21/16, 10/11/16 28 Pa Code 211.10(d) Resident care policies Previously cited 09/29/17, 09/15/17, 04/19/17, 03/06/17, 10/11/16 28 Pa. Code 211.11(c)(d) Resident care plan 28 Pa Code 211.12(c)(d)(1)(5) Nursing services Previously cited 09/29/17, 09/15/17, 04/19/17, 03/06/17, 12/21/16, 10/11/16