STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	2350 TAFT ST GARY, IN 46404

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F000000	This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/18/13. This visit was in conjunction to the Post Survey Revisit (PSR) to the Investigation of Complaints IN00140612 and IN00141984 completed on 1/3/14. This visit was in conjunction with the Investigation of Complaints IN00144034, IN00144168, IN00144315 and IN00144336. Survey dates: February 11, 12 and 13, 2014 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Survey team: Cynthia Stramel, RN, TC Yolanda Love, RN Heather Tuttle, RN 2/13/14 Lara Richards, RN 2/13/14 Census bed type: SNF: 13	F000000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute 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 provisions of federal and state law.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	SNF/NF: 122 Total: 135 Census payer type: Medicare: 23 Medicaid: 105 Other: 7 Total: 135 These deficiencies reflect State findings in accordance with 410 IAC 16.2. Quality review completed on Febuary 20, 2014, by Janelyn Kulik, RN.			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F000282	1) Immediate actions taken for those residents identified:· Resident #62 was referred to therapy for re-evaluation on 2/14/14 for contracture and splint management. 2) How the facility identified other residents:· Audit was completed of all residents with orders for anti-contracture devices to ensure	03/02/2014

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			devices were applied as ordered. 3) Measures put into place/ System changes:· Nursing staff will be re-educated regarding application of anti-contracture devices per physician orders and plan of care.· Observation rounds will be completed on at least 5 residents with anti-contracture devices per day 5x/week and will be verified by 2 nursing managers to ensure compliance. Resident #62 will be included in observations at least 5x/week. · The Director of Nursing and Restorative Nurse will be responsible for oversight of these audits. 4) How the corrective actions will be monitored:· The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.· Staff non-compliant with plan of correction will be disciplined up to and including termination.	
	Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to ensuring anti-contracture devices were in place for 1 of 3 residents reviewed for range of motion (ROM). (Resident #62) Findings include:			

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	On 2/12/14 at 1:40 p.m., Resident #62 was observed laying in her bed. Her hands were contracted, she was not wearing a splinting device. On 2/13/14 at 10:30 a.m., the resident was observed laying in her bed, she was not wearing a splinting device on her hands. She had a splinting device on her right knee. The resident's record was reviewed on 2/13/14 at 10:00 a.m. The resident was readmitted to the facility on 10/10/13. The resident's diagnoses included, but were not limited to, cerebral vascular accident (CVA) and quadriplegia. The Quarterly Minimum Data Set (MDS) Assessment dated 1/13/14, indicated the resident was rarely or never understood, was dependant for personal hygiene and dressing, and required extensive two person assistance for bed mobility. A Care Plan updated 12/18/13 indicated the problem of contracture management. The goal was to provide contracture management through the next review. Approaches included direct care staff to apply palm protectors in the			

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	morning and remove after lunch. Interview with Restorative Aide #1 on 2/13/14 at 10:30 a.m., indicated she did not apply the palm protectors during care. She would provide range of motion exercises to the residents legs and apply the knee splint. She indicated the CNA's were supposed to apply the palm protectors for the resident. Interview with CNA #1 on 2/13/14 at 11:00 a.m., indicated she was routinely assigned to care for Resident #62 and was familiar with her. She indicated the Restorative Aide applied the palm protectors, she indicated she had never applied palm protectors to that resident. Review of the residents Kardex (CNA care plan) at that time indicated direct care staff was to apply palm protector before breakfast and remove after lunch. The CNA indicated she was not aware of that item on the Kardex. This deficiency was cited on 11/18/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)			

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F000318 SS=D	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 receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F000318	1) Immediate actions taken for those residents identified:· Resident #62 was referred to therapy for re-evaluation on 2/14/14 for contracture and splint management. 2) How the facility identified other residents:· Audit was completed of all residents with orders for anti-contracture devices to ensure devices were applied as ordered. 3) Measures put into place/ System changes:· Nursing staff will be re-educated regarding application of anti-contracture devices per physician orders and plan of	03/02/2014

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			care.· Observation rounds will be completed on at least 5 residents with anti-contracture devices per day 5x/week and will be verified by 2 nursing managers to ensure compliance. Resident #62 will be included in observations at least 5x/week. · The Director of Nursing and Restorative Nurse will be responsible for oversight of these audits. 4) How the corrective actions will be monitored:· The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.· Staff non-compliant with plan of correction will be disciplined up to and including termination.	
	Based on observation, record review, and interview, the facility failed to ensure a resident received appropriate treatment for contractures to prevent further decrease in range of motion for 1 of 3 residents reviewed for range of motion. (Resident #62) Findings include: On 2/12/14 at 1:40 p.m., Resident #62 was observed laying in her bed. Her hands were contracted, she was not wearing a splinting device. On 2/13/14 at 10:30 a.m., the			

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	resident was observed laying in her bed, she was not wearing a splinting device on her hands. She had a splinting device on her right knee. The resident's record was reviewed on 2/13/14 at 10:00 a.m. The resident was readmitted to the facility on 10/10/13. The resident's diagnoses included, but were not limited to, cerebral vascular accident (CVA) and quadriplegia. The Quarterly Minimum Data Set (MDS) Assessment dated 1/13/14 indicated the resident was rarely or never understood, was dependant for personal hygiene and dressing, and required extensive two person assistance for bed mobility. A Care Plan updated 12/18/13 indicated the problem of contracture management. The goal was to provide contracture management through the next review. Approaches included direct care staff to apply palm protectors in the morning and remove after lunch. Interview with Restorative Aide #1 on 2/13/14 at 10:30 a.m., indicated she did not apply the palm protectors during care. She would provide range of motion exercises to			

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	the residents legs and apply the knee splint. She indicated the CNA's were supposed to apply the palm protectors for the resident. Interview with CNA #1 on 2/13/14 at 11:00 a.m., indicated she was routinely assigned to care for Resident #62 and was familiar with her. She indicated the Restorative Aide applied the palm protectors, she indicated she had never applied palm protectors to that resident. Review of the residents Kardex (CNA care plan) at that time indicated direct care staff was to apply palm protector before breakfast and remove after lunch. The CNA indicated she was not aware of that item on the Kardex. This deficiency was cited on 11/18/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-42(a)(2)			

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