

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2014
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NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 19, 20, 21, 22, 23, 2014</p> <p>Facility number: 000541 Provider number: 155475 AIM number: N/A</p> <p>Survey team: Tim Long RN-TC Carol Miller, RN Rick Blain, RN Diane Nilson, RN</p> <p>Census bed type: SNF: 12 Residential: 167 NCC: 46 Total: 225</p> <p>Census Payor type: Medicare: 12 Other: 213 Total: 225</p> <p>Sample: Residential: 8 NCC: 3</p>	F000000		

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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F000157 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16..</p> <p>Quality review completed on May 27, 2014 by Randy Fry RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>			

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of a significant weight loss for 1 of 5 residents reviewed for nutrition (Resident #21). In addition the facility failed to notify the physician of elevated blood glucose levels for 1 of 3 residents (#9) reviewed for blood glucose levels.</p> <p>Findings include:</p> <p>1. The record for Resident #21 was reviewed on 5/21/2014 at 9:00 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>Weights provided by the facility on 5/19/2014 indicated the following weights:</p> <p>02/22/2014: 105.8 lbs 02/25/2014: 107.2 lbs 03/18/2014: 99.2 lbs (7.46% decrease from 2/25/14) 03/25/2014: 99.6 lbs (7.09% decrease from 2/25/14) 05/20/2014: 98.8 lbs (7.83% decrease from 2/25/14)</p> <p>There was no documentation in in the Physician Progress notes addressing the</p>	F000157	<p>The Towne House does not agree with this finding. However, as part of the certification process, this plan of correction has been developed to meet the requirements of the program. All residents that have experienced weight loss in the past 30 days have been reviewed by the nursing staff and by the clinical dietician. There were two residents that had experienced weight loss. The residents' physicians have been notified about the weight loss. In the future, nurses will receive weekly reports on all new weights of residents from the certified dietary manager. Information from the CDM on weight loss along with current measures being used will be provided to the physician in a timely manner. Orders for all residents that had elevated blood glucose were reviewed by the nursing staff. There were no additional residents that had orders to contact their physician to let them know when the blood glucose level was elevated. Orders have been rewritten so that the notification to the physician will be the first item on the order instead of the last part of the order. This will draw attention to the fact that the nurse needs to contact the physician. In-service training will be provided</p>	06/22/2014	

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	<p>resident's weight loss.</p> <p>There was no documentation in Resident 21's record indicating the nursing staff had notified the physician of weight loss occurring on 3/18/14, 3/25/14, or 5/20/14.</p> <p>The facility DON (Director of Nursing) was interviewed on 5/21/2014. During the interview, the DON indicated there was no documentation in Resident #21's chart to indicate the facility had notified the physician of the resident's significant weight loss.</p> <p>A facility policy entitled "Weight Policy", with a revised date of 11/2006, was provided by the DON on 5/21/2014 at 10:30 A.M. The policy indicated residents with weight changes of 5% in one month, 7% in three months, or 10% in six months would be considered to be at nutritional risk. The policy further indicated "If weight loss verified, the attending physician will be notified...."</p> <p>2. Resident #9's clinical record was reviewed on 5/20/14 at 3:00 P.M. and indicated the resident was admitted to the facility on 3/4/14 and had diagnoses including, but not limited to, carotid artery stenosis, hypertension, chronic anemia and diabetes mellitus.</p>		<p>prior to June 22, 2014 to address these changes. In addition, the quality assurance program will be modified so that the Director of Nursing / Medical Records Nurse will be auditing charts on a quarterly basis to ensure that notifications have consistently been done. The Director of Nursing will monitor for compliance</p>	

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	<p>Review of the resident's physician's orders dated 4/22/14 indicated to administer Humalog (insulin for diabetes mellitus) per a sliding scale based on a blood glucose level done before each meal and at bedtime. The sliding scale indicated if the blood glucose was over 301, the resident was to be administered Humalog 10 units and physician was to be notified.</p> <p>Review of the Medication Administration Record (MAR) for May 2014, indicated from 5/2/14 through 5/10/14, the resident's blood glucose level was over 301 a total of 12 times. Review of the MAR and the nurse's notes indicated the physician was not notified on any of the 12 occasions when the blood glucose level was above 301.</p> <p>On 3/11/14, a physician's order was received to change the sliding scale for Humalog administration and if the blood glucose was above 351, to give 10 units of Humalog and call the physician.</p> <p>Review of the MAR from 5/11/14 through 5/19/14 indicated the resident's blood glucose level was above 351 a total of 8 times. Review of the MAR and the nurse's notes indicated the physician was not notified on 7 of the 8 occasions.</p>			

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	<p>An interview with the Director of Nursing (DON) on 5/21/14 at 11:00 A.M. indicated the physician should have been notified on each occasion when resident #9's blood glucose was above the appropriate levels (over 301 from 5/2/14 through 5/10/14 and above 351 from 5/11/14 through 5/19/14) as the physician's orders indicated.</p> <p>Review of a procedure provided by the DON on 5/21/14 at 11:15 A.M., with the subject of: "Physician Notification Procedure/Family/POA/Administrative Personnel" indicated: 1. Notify physician, family or POA and administrative personnel (on call nurse) immediately (day or night) of any significant changes in condition and/or accidents or injuries. 2, Notify physician, family or POA and administrative personnel (on call nurse) as soon as possible or by the next morning (if during night shift), minor occurrences/incidents or weight loss (example: non emergency issues).</p> <p>3.1-5(a)(2)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to obtain laboratory tests as ordered by the physician, for 1 of 5 residents reviewed for nutrition (Resident #21). The facility also failed to notify the physician of elevated blood glucose levels, per the physician's orders for 1 of 3 residents (#9) reviewed for diabetes mellitus.</p> <p>Findings include:</p> <p>1. The record for Resident #21 was reviewed on 5/21/2014 at 9:00 A.M. Diagnoses included, but were not limited to, hypertension (high blood pressure).</p> <p>A laboratory report, dated 2/23/2014, indicated results of a CBC (complete blood count) was received by the facility on 2/27/2014. A hand written note on the report from the physician, dated</p>	F000282	<p>The Towne House does not agree with this finding. However, as part of the certification process, this plan of correction has been developed to meet the requirements of the program. In this finding, the lab order was not properly transcribed from the physician's order to the lab requisition form and the medication administration record. All residents that have orders for lab reports have been reviewed. There were seven residents that had lab orders. All residents with lab orders have appropriate documentation that the order was followed. In the future, orders will be properly transcribed from the physician's order to the lab requisition form and the medication administration record. One nurse from each shift will review the order and requisition and the Director of Nursing will also check the order. Glucose levels were monitored and medications were provided by staff members appropriately</p>	06/22/2014

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F000314 SS=D	<p>2/28/2014, indicated "anemia noted - has patient had iron deficiency panel or treatment for anemia?" A hand written response on the report from the facility staff indicated "no."</p> <p>A physician order, dated 3/3/2014, indicated a ferritin level, serum iron level, reticulocyte count, folate level, and vitamin B 12 level were to be obtained on 3/6/2014.</p> <p>There were no results for the laboratory tests ordered on 3/3/2014 in Resident #21's record.</p> <p>The facility DON (Director of Nursing) was interviewed on 5/21/2014 at 11:30 A.M. During the interview, the DON indicated the laboratory tests ordered by the physician on 3/3/2014 had not been obtained. The DON indicated when nursing staff receive an order for laboratory tests, the staff are to either call or fax the order to the lab. The DON further indicated she had called the lab and they had indicated they had not received the physician order from the facility for the laboratory tests ordered on 3/3/2014.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of</p>		<p>when the glucose level was elevated. Orders for all residents that had elevated blood glucose were reviewed by the nursing staff. There were no additional residents that had orders to contact their physician to let them know when the blood glucose level was elevated. Orders have been rewritten so that the notification to the physician will be the first item on the order instead of the last part of the order. This will draw attention to the fact that the nurse needs to contact the physician. In-service training will be provided prior to June 22, 2014 to address these changes. In addition, the quality assurance program will be modified so that the Director of Nursing / Medical Records Nurse will be auditing charts on a quarterly basis to ensure that orders have consistently been transcribed to the lab requisition form, medication administration record, and completed properly. The Director of Nursing/Medical Records Nurse will also audit charts of residents who have blood glucose levels monitored to verify notification of the physician has occurred. The Director of Nursing will monitor for compliance.</p>				

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	<p>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 sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure timely skin assessments were completed after a resident developed pressure sores, for 1 of 3 residents, Resident #14, who was reviewed for Pressure Sores.</p> <p>Findings include:</p> <p>Resident # 14 was observed in a wheelchair in her room with TED hose on her bilateral extremities, at 9:00 a.m., on 5/20/14. An air mattress was observed on the resident's bed.</p> <p>The Director of Nursing Services (DNS), was interviewed, at 9:43 a.m., on 5/20/14, and indicated the physician had seen Resident #14 on 4/18/14, and assessed her outer right foot pressure ulcer area. She indicated the pressure ulcer was a blister and had originated on 4/9/14.</p> <p>The record for Resident #14 was reviewed, at 1:10 p.m., on 5/20/14 and</p>	F000314	<p>The Towne House does not agree with this finding. However, as part of the certification process, this plan of correction has been developed to meet the requirements of the program. Assessments on skin conditions of Resident #14 were completed on 3/28/14, 4/01/14, 4/08/14, 4/14/14, 4/21/14, 4/25/14, 5/06/14, 5/13/14, 5/16/14, 5/19/14, and 5/23/14 in addition to the assessments completed on 4/9/14, 4/22/14, 4/24/14 and 4/29/14 that were noted in the finding. In addition, the "ulcer and pressure ulcer staging" form which is an assessment form was initiated by a nurse so the physician could complete an assessment on 4/18/14. The physician reviewed the resident's skin condition on 4/18/14 and treatment was provided as ordered. All residents with open areas had assessments reviewed and it was noted that all residents had consistent and timely skin assessments. In the future, nurses will complete weekly skin assessments and document findings on skin assessment</p>	06/22/2014			

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	<p>indicated the resident was admitted to the skilled care unit on 3/28/14. Diagnoses included, but were not limited to: Right humerus fracture, right hip and sacral fractures(3/21/14), malnutrition, acute hypoxia, senile dementia, atrial fibrillation, osteoarthritis, edema, osteoporosis, Heterozygous Factor V Leiden Mutation, Chronic kidney disease, Perpheral Arterial disease, and chronic iron deficiency anemia.</p> <p>Review of a physician progress note, dated 4/18/14, indicated the physician was asked to evaluate a wound. Review of an "Ulcer and pressure ulcer staging" form, dated 4/18/14, and signed by the physician, indicated the ulcer type as "pressure ulcer-unrelieved pressure", and Eschar(necrotic tissue) on the heel at least a stage 3. The stages of pressure ulcers were listed on the form and both stage 3 and stage 4 were circled.</p> <p>Review of a consultation report from the wound clinic, dated 4/23/14, indicated the resident was seen for a consultation for bilateral heel ulcers. The report indicated the resident fell on 3/21/14 and incurred a fracture to the right arm, right hip and sacral fracture and developed heel ulcers during the recovery period. The report indicated the resident had a stage 1 pressure ulcer located on the left</p>		<p>forms. The "ulcer and pressure ulcer staging" form will be signed and dated by the nurse initiating the form. The skin committee consisting of nursing and dietary staff will meet weekly to review for timely assessment dates, notifications and effectiveness of treatments. In-service training will be provided prior to June 22, 2014 to address this change. As part of the quality assurance program, the director of nursing will audit charts on a quarterly basis to ensure that assessments have been completed accurately and timely. The Director of Nursing will monitor for compliance.</p>		

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	<p>heel which was thought to be related to immobility. The area measured 3.2 cm. by 2 cm. by 0.1 cm., and had no exudate draining from the pressure ulcer. The plan for the pressure ulcer indicated to apply mepilex ag and kerlix and to apply compression with compression stockings. This was to be done twice per week. The report further indicated there was a Stage 2 partial thickness pressure ulcer located on the right heel which was thought to be related to immobility. This area measured 10 cm. by 2.3 cm. by 0.1 cm. There was a minimum amount of serous exudate draining from the pressure ulcer. The report indicated the skin around the pressure ulcer was macerated, and the plan for treatment was to apply mepilex ag(a dressing used for wounds), zinc, a profore boot and compression with an Unnaboot. The treatment indicated this was to be done one time per week for 3 days.</p> <p>The section under Skin examination indicated there was 2+ pitting edema with faint erythema to the Right lower extremity, and a necrotic heel ulcer with light, superficial fluctuance. The report also indicated there was 2+ pitting edema with faint erythema to the Left lower extremity, with an Intact full thickness blister.</p> <p>The treatment plan indicated the resident was to return to the wound clinic on</p>			
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	<p>5/5/14 to recheck the wounds, and Selective debridement of the bilateral heel wounds was performed on this visit. The Impression section of the report indicated Stage 2 pressure ulcers to the bilateral heels with mild venous stasis dermatitis, and the factors which likely contributed to the edema included significant venous insufficiency, and reduced muscle pump activity due to mobility problems.</p> <p>RN #6 was observed performing a dressing change and wound care on the right heel area, at 3:50 p.m., on 5/20/14. The resident was lying in bed and a CNA was assisting the RN by holding the resident's right leg up, as the RN removed the Ted Hose, removed the old dressing, cleansed the heel area, and measured the pressure area on the right heel. The nurse indicated the area measured 6 centimeters (cm) by 2 cm. The RN then applied a thin layer of Santyl, then mepilex and a dry sterile dressing. The RN indicated the pressure area looked much better.</p> <p>The Resident's record was reviewed with the Director of Nursing Services(DNS), at 9:00 a.m., on 5/21/14. A skin assessment form, dated 4/9/14, indicated there was a partial thickness pressure ulcer noted on the right outer foot which originated on 4/9/14. The</p>			

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	<p>area measured 5.0 centimeters (cm) by 7.0 cm and was described as a fluid filled blister to the outer right heel area, with serous drainage.</p> <p>An interdisciplinary note, dated 4/9/14 at 4:51 a.m., indicated the right outer heel area was wrapped with kling and no further drainage" noted/fluid filled blister."</p> <p>The DNS indicated residents received a full assessment on a daily basis.</p> <p>The DNS indicated even though not documented, the nurse would have called the physician's office on 4/9/14 and alerted the physician that the resident would be added to the list to be seen on 4/11/14 and list the reason why the resident would be seen.</p> <p>A nursing note daily summary, dated 4/11/14, indicated the resident was seen by the physician and an order received for bacitracin and a dry sterile dressing ordered for the right foot blister.</p> <p>The DNS indicated all residents used pressure reduction mattresses and this resident was non-weight bearing and as a nursing measure used heel protectors.</p> <p>The DNS indicated the resident was evaluated every week to see if treatments needed to be changed.</p> <p>The DNS indicated every Tuesday a skin assessment was completed by the nurse working on the unit.</p> <p>Review of the skin assessment forms</p>			

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	<p>indicated assessments were completed on the following dates: 4/9/14 4/22/14 4/24/14 4/29/14</p> <p>There was no documentation a skin assessment had been completed between 4/9 and 4/22/14. The DNS indicated she could not find a skin assessment between 4/9/14 and 4/22/14, however a nursing daily summary, dated 4/15/14, indicated a dressing change had been completed on the right ankle on 4/15/14. The DNS indicated the area on the right outer foot was healed on 4/29/14. The next skin assessment for the right outer foot , dated 4/24/14, indicated the pressure ulcer measured 5.0 by 7.0 centimeters with serous drainage, and was described as a fluid filled blister. The category area listed the pressure ulcer as a partial thickness wound. The final skin assessment, for the right outer foot, dated 4/29/14, indicated the area was healed.</p> <p>Even though the physician was called in to observe the resident's foot on 4/18/14, and indicated there was a stage 3-4 pressure ulcer on the right heel, there was no documentation a skin assessment was completed on the area until 4/22/14.</p>				

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	<p>A skin assessment, dated 4/22/14, indicated a persistent skin redness, pressure ulcer, to the left heel, which measured 3.0 by 3.0 centimeters, the wound edge was white, no drainage. The treatment area indicated to elevate the heels off of the bed.</p> <p>A skin assessment, dated 4/22/14, indicated a persistent skin redness pressure ulcer on the right heel, measuring 4.0 cm by 5.0 cm , no depth, and the treatment indicated to keep the heels off of the bed. The description of the area indicated , "discoloration, bluish in color with patchy white area around the area"</p> <p>A skin assessment, dated 4/29/14, indicated the resident was being seen at the wound clinic and being treated with mepilex dressing two times weekly. The area measured 6.4 cm by 3.0 cm no depth, with same description as on 4/22/14.</p> <p>A skin assessment, dated 5/6/14, indicated still seen at the wound clinic , same treatment, 6.0 by 2.2 cm no depth, and "discoloration, bluish in color with patchy white area around the area, patchy brown areas.</p> <p>CNA #8 was interviewed, at 11:16 a.m., on 5/21/14, and indicated she had taken</p>			

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	<p>care of Resident #14 since her admission. She indicated the resident was showered by staff on Tuesdays and Fridays, and the CNAs checked the resident's skin and would report anything unusual to the nurses. She indicated a partial bath was given to the resident on a daily basis and at that time, the resident's skin was also checked for bruising, red areas, and anything unusual, and the CNAs also checked the resident's feet when they applied lotion, and would report if they saw anything unusual.</p> <p>She indicated she had not had to report any skin conditions to the nurse.</p> <p>The DNS was interviewed, at 1:50 p.m., 5/21/14, and indicated the physician had assessed the resident's foot on 4/18/14, and RN #10 had done rounds with the physician on 4/18/14. The DNS indicated RN #10 had told her the physician looked at the "heel" not the right side of the foot. She indicated the assessments showed the resident had a blister on the right side of the foot. She indicated the physician observed an area on the right heel that the facility had not observed prior to this. The DNS indicated she was not aware of this area on the right heel until she was informed on 4/22/14. She indicated after she was informed of the pressure ulcer on the right heel, she went to assess the area</p>						

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	<p>herself, and then suggested the resident be seen at the wound clinic. She indicated an appointment was set up, and the resident was went to the wound clinic on 4/23/14. She indicated the physician staged the pressure ulcer on the right heel at a stage 3-4.</p> <p>RN #10 was interviewed, at 3:14 p.m., on 5/21/14, and indicated she did the rounds with the physician every Friday. She indicated she had done the rounds with the physician on 4/18/14, and had been with the physician when he visited Resident #14. She indicated the physician looked at the resident's foot and indicated there was eschar on the resident's heel. RN #10 indicated she couldn't remember if she saw the resident's heel, but the physician observed the resident's foot and told the RN to keep pressure off of the heel. The RN indicated she then got the resident a different pair of heel protectors, "profo boots" which she indicated kept the resident's feet higher off of the bed. She indicated prior to this, the resident was wearing "waffle" boots. She indicated the physician did not order any other treatment, but only to keep pressure off of the heel. She indicated the physician did order a treatment for the area on the side of the right foot, vaseline and optifoam dressing, and also had ordered an air</p>			

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	<p>mattress the same day.</p> <p>The DNS provided a note she had written regarding the pressure ulcer, and additional documentation on "interdisciplinary notes" in which she had highlighted notes for review, at 4:30 p.m., on 5/21/14.</p> <p>The note and additional "interdisciplinary notes" were reviewed, at 5:00 p.m., on 5/21/14, and indicated the following: The note indicated early on the nurses were documenting dressing changes to the right heel in some of their nursing notes. The note indicated the DNS thought the area discovered on 4/18/14 by the physician, may have been a continuation of the original 4/9/14 skin issue, which was titled right outer foot/heel/ankle. She indicated this also supports possibly what the wound clinic was seeing. Review of the "interdisciplinary notes" indicated the following: A note, dated 4/09/14 indicated the right outer heel area was wrapped with kling, no further drainage noted/fluid filled blister; A note, dated 4/11/14 indicated the right outer ankle blister popped and was rewrapped. Another note on 4/11/14 indicated the dressing to the right heel was changed.</p>						

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	<p>A note, dated 4/14/14 indicated the dressing was changed to the right heel.</p> <p>A note, dated 4/15/14 indicated the dressing was changed to the right ankle.</p> <p>A note, dated 4/16/14 indicated the dressing was dry and intact to the right lower outer foot.</p> <p>A note, dated 4/16/14 (same day) indicated the dressing was changed to the right heel.</p> <p>A note, dated 4/17/14 indicated the dressing was changed to the right heel.</p> <p>The wound clinic RN was interviewed on the telephone, at 10:13 a.m., on 5/22/14 regarding the pressure ulcers and documentation from the wound clinic. She indicated she was not present during this visit, but from the documentation she had reviewed, it looked like the entire area including the heel and right side of the foot were measured, but she was not sure because she was not present. She indicated she initially thought the 10 centimeter(cm) by 2.3 cm measurement could have been 1.0 cm by 2.3 cm, but because the measurement on the 5/7/14 visit showed measurements of 5.0 cm by 2.2 cm by 0.2 cm, she thought the 10 cm documentation was probably correct. She indicated measurements were done before and after debridement, and the measurements on the 4/23/14 visit were</p>			

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	<p>the same before and after debridement. She indicated she was not sure why the area was documented as a stage 2 on the right heel, but indicated anything with eschar could not be staged. She also indicated selective debridement could be "just picking off a scab or the skin off of a blister. "</p> <p>The policy for pressure sores and skin problems, dated as revised on October, 2006, was provided by the DNS at 8:53 a.m., on 5/22/14.</p> <p>Review of the policy, at 9:00 a.m., on 5/22/14, indicated the following:</p> <p>Skin observations were made daily during the performance of bathing and dressing the residents by the CNAs. The CNAs are responsible for promptly notifying the charge nurse of all observations including redness, bruises, skin tears, blisters, excoriation, drainage, crusts, scales, any type of lesion, skin discoloration, and open areas.</p> <p>Weekly skin audits were completed by the charge nurse on any new resident being admitted to the facility for the length of their stay if they were staying in a medicare room.</p> <p>Decubitus(pressure) ulcers and skin problems would promptly be reported to the attending physician and family member. Any stage 3 or 4 decubitus sores must be reported to the family and</p>			

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	<p>physician immediately and an order obtained to send the resident to the wound clinic.</p> <p>Decubitus ulcers and other skin lesions would be measured weekly by a licensed nurse and documented on the integument sheet.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to implement recommendations made by the Registered Dietitian, for 3 of 5 residents reviewed for Nutrition (Resident #21, 14, 24).</p> <p>Findings include:</p> <p>The record for Resident #21 was reviewed on 5/21/2014 at 9:00 A.M. Diagnoses included, but were not limited to, dementia.</p>	F000325	The Towne House does not agree with this finding. However, as part of the certification process, this plan of correction has been developed to meet the requirements of the program. All current recommendations made by the dietician have been reviewed by the supervising dietician regarding supplements for all residents, and there were no residents that had orders that needed to be updated. In the future, the dietician will forward recommendations to the CDM and these recommendations will be forwarded to the charge	06/22/2014

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	<p>Weights provided by the facility on 5/19/2014 indicated the following weights:</p> <p>02/22/2014: 105.8 lbs 02/25/2014: 107.2 lbs 03/18/2014: 99.2 lbs (7.46% decrease from 2/25/14) 03/25/2014: 99.6 lbs (7.09% decrease from 2/25/14) 05/20/2014: 98.8 lbs (7.83% decrease from 2/25/14)</p> <p>A physician's order, dated 3/7/2014, indicated the resident was to receive Med Pass (nutritional supplement) 4 oz (ounces) twice daily for a low BMI (body mass index).</p> <p>An Interdisciplinary Note by the Registered Dietitian (RD), dated 3/20/2014, indicated "...Resident's weight on 3/18/14 was 99.2 # (pounds). Current BMI is 18.1. Have seen a 6.1% loss since admission from hospital on 2/22/14. Recommend increasing Med Pass house supplement to (4 oz) TID (three times daily). Will continue to monitor weight & labs."</p> <p>The Medication Administration Record (MAR) for March 2014, indicated the Med Pass was increased from twice daily</p>		<p>nurse. In the absence of the CDM, another dietary manager will forward the information to the charge nurse. The charge nurse will notify the physician, document and implement the order. If the physician disagrees with the recommendation, the charge nurse will document the response in the medical record. Copies of recommendations will be sent to the Director of Nursing and Food Service Director. The Director of Nursing will monitor, and the Dietician will follow up on the next visit to ensure that the recommendation has been followed through. In-service training will be provided prior to June 22, 2014 to address this change. As part of the quality assurance program, the director of nursing and food service director will audit charts on a quarterly basis to ensure that dietary recommendations have been completed accurately and timely. The Director of Nursing will monitor for compliance.</p>				

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	<p>to three times daily on 3/26/2014.</p> <p>The April 2014 MAR indicated the Med Pass was again being given twice daily for low BMI.</p> <p>The MAR for May 2014 indicated the Med Pass was to be administered TID. The "TID" was crossed off, and "BID" was hand written onto the MAR. The MAR indicated the Med Pass was being administered twice daily at 8:00 A.M. and 5:00 P.M.</p> <p>A Physician's Order monthly recap for May 2014 indicated Med Pass was to be administered three times daily due to low BMI and to prevent weight loss. The "three times daily" was crossed off and "twice" was hand written onto the recap.</p> <p>LPN #3 was interviewed on 5/21/2014 at 10:15 A.M. During the interview, LPN #3 indicated she had changed the Med Pass instructions on the May 2014 MAR from three times daily back to two times daily because she had not seen a physician's order for Med Pass to be given three times daily in Resident #21's chart.</p> <p>RN #5 was interviewed on 5/21/2014 at 10:15 A.M. During the interview, RN #5 indicated she had changed the Med Pass</p>				

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	<p>order on the May 2014 monthly recap from three times daily to twice daily because she had not seen any physician's order for Med Pass three times daily in Resident #21's chart.</p> <p>RN #4 was interviewed on 5/21/2014 at 10:00 A.M. During the interview, RN #4 indicated she had received the recommendation from the RD to increase the Med Pass from twice daily to three times daily in March 2014 and thought she had written an order and sent the order to pharmacy but she was unable to locate the order in Resident #21's chart.</p> <p>The facility DON was interviewed on 5/21/2014 at 2:00 P.M. During the interview, the DON indicated nutritional supplements such as Med Pass were documented on the MARs. The DON further indicated the April 2014 MAR for Resident #21 had been checked for accuracy on 3/19/2014 by nursing staff. She indicated that since the Med Pass had been increased on 3/26/2014, after the April MAR had been reviewed by the nurse, the new orders for the Med Pass had not been transcribed onto the April 2014 MAR. The DON indicated she could not find a copy of the order changing the Med Pass from BID to TID in Resident #21's chart. She indicated the order might have been misplaced, but</p>			

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F000431 SS=D	<p>could not be sure. The DON further indicated she thought the pharmacy would not have printed the order to increase the Med Pass on the May 2014 MAR and May 2014 monthly recap without receiving an order. The DON indicated, based on the RD recommendation, Resident #21 should have been receiving the Med Pass three times daily.</p> <p>The facility's consultant RD was interviewed on 5/22/2014 at 12:30 P.M. During the interview, consultant RD indicated, based on on the RD's recommendations in March 2014 and Resident #21's current weight, the resident should be receiving the Med Pass three times daily.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>						

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	<p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an accurate account of controlled medications was maintained, in 1 of 1 medication carts during a narcotic count.</p> <p>Findings include:</p> <p>A narcotic count was conducted, with RN #4, at 1:13 p.m., on 5/21/14, on the medication cart on the skilled hall. The narcotic count for Resident #38 indicated the resident was receiving Lorazepam 0.5 milligrams. There were 25 Lorazepam tablets remaining in the bubblepack for the resident, however, on the line beside the 25th tablet, the number was circled and signed by 2 nurses. RN #4 indicated one of the lorazepam tablets was wasted</p>	F000431	The Towne House does not agree with this finding. However, as part of the certification process, this plan of correction has been developed to meet the requirements of the program. Resident #38 was admitted to the SNF midway through the survey and it was determined that the controlled substance counts was not accurate for one medication. All controlled medications have been counted in the SNF, NCC, and licensed residential area and all counts were accurate. The policy for counting controlled substance medications was updated to include a weekly audit by the director of nursing/or her designee. In-service training will be provided prior to June 22, 2014 to address this change. As part of the quality assurance program, the director of nursing	06/22/2014

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NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825
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	<p>on 5/21/14 so 2 nurses had to sign because the medication was wasted. RN #4 indicated she was one of the nurses who co-signed the medication being wasted. She indicated there should be 24 Lorazepam tablets, not 25. The Controlled Drug Use record indicated 5 entries on the record as follows: (30 tablets sent from the pharmacy) 5/1/14 12:00 p.m., one tablet given, with 29 remaining tablets; 5/3/14 8:00 a.m., one tablet given with 28 remaining; 5/9/14 11:00 a.m., 1 tablet given with 27 remaining; 5/13/14 8:00 p.m., 1 tablet given with 26 remaining; 5/21/14 3:30 (did not indicate a.m. or p.m.) 1 tablet (circled) with 25 remaining. Underneath the 25 indicated "wasted" with 2 nurse's signatures.</p> <p>RN # 4 indicated resident # 38 had just been admitted to health care from the Residential side on 5/20/14 and the count could have been off from the Residential area.</p> <p>The Director of Nursing Services (DNS) was interviewed, at 2:47 p.m., on 5/21/14, and indicated the nurse on Residential signed out a Lorazepam tablet on 5/13/14, but did not give the lorazepam. She indicated the count on</p>		<p>or designee will audit controlled substance medications on a weekly basis to ensure that counts are accurate and incorporate this information on a quarterly basis. The Director of Nursing will monitor for compliance.</p>	

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F009999	<p>5/13/14 should then have been 27, not 26 tablets. , so when the nurses wasted the tablet on 5/21/14, the tablet wasted should have been #26 tablet. (which would leave the count at 25.)</p> <p>The policy "Reconciliation of Controlled Medications", dated February 1, 2007 and revised in June 2012, was provided by the DNS, at 12:05 p.m., on 5/22/14. Review of the policy, at 12:15 p.m., on 5/22/14, indicated the following: A record of usage and disposition of all controlled medications with sufficient detail to allow reconciliation; All schedule 11/controlled medications would be reconciled on a shift-to-shift basis daily by two licensed nurses.</p> <p>3.1-25(n)</p>	F009999	The Towne House does not agree with this finding. However, as part of the certification process, this plan of correction has been developed to meet the requirements of the program. All current recommendations made by the dietician have been	06/22/2014	
	<p>3.1-46 Nutrition and hydration. Sec. 46. (a) Based on a resident's comprehensive assessment and care plan, but subject to the resident's right to refuse, the facility must ensure the following:</p>				

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	<p>(1) that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interviews and record reviews, the facility failed to ensure a Dietary recommendation was followed.</p> <p>This deficiency affected 1 of 1 resident in a sample of 3 residents in regard to dietary recommendations (Resident #7).</p> <p>Findings include:</p> <p>The clinical record of Resident #7 was reviewed on 5/21/14 at 11:00 a.m. Resident #7's diagnosis included, but were not limited to, anxiety, depression, and Alzheimer's disease.</p> <p>The Interdisciplinary Note (IDT) dated 5/15/14 indicated a Dietary recommendation from the Facility Registered Dietician (RD) for the supplement Med Pass 4 ounces</p>		<p>reviewed by the supervising dietician regarding supplements for all residents, and there were no residents that had orders that needed to be updated. In the future, the dietician will forward recommendations to the CDM and these recommendations will be forwarded to the charge nurse. In the absence of the CDM, another dietary manager will forward the information to the charge nurse. The charge nurse will notify the physician, document and implement the order. If the physician disagrees with the recommendation, the charge nurse will document the response in the medical record. Copies of recommendations will be sent to the Director of Nursing and Food Service Director. The Director of Nursing will monitor, and the Dietician will follow up on the next visit to ensure that the recommendation has been followed through. In-service training will be provided prior to June 22, 2014 to address this change. As part of the quality assurance program, the director of nursing and food service director will audit charts on a quarterly basis to ensure that dietary recommendations have been completed accurately and timely. The Director of Nursing will monitor for compliance.</p>		

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	<p>two times a day due to a low Albumin level (a laboratory test).</p> <p>The May 2014 Treatment Administration Record indicated no documentation that the supplement Med Pass had been given to the resident.</p> <p>Interview on 5/21/14 at 2:15 p.m. with the Certified Dietary Manager (CDM) #1 indicated when the RD makes a recommendation the RD contacts the CDM and the CDM contacts Nursing and Nursing notifies the Physician. CDM #1 further indicated CDM #11 had been on vacation when the RD had written the recommendation for the supplement med pass for Resident #7.</p> <p>The Physician's Order dated 5/21/14 indicated Med Pass supplement 2 times a day for a low Albumin level for Resident #7.</p> <p>Interview on 5/22/14 at 12:45 p.m. with the RD Consultant indicated there was no CDM replacement while CDM #11 was on vacation.</p>				

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R000000	<p>Interview on 5/23/14 at 10:20 a.m. with CDM #11 indicated when she came back from her vacation Resident #7's IDT note for the dietary recommendation dated 5/15/14 was on her desk. CDM #11 further indicated while she was off work there was no one to act as her replacement.</p> <p>This deficiency reflects state finding cited in accordance with 410 IAC 16.2-5.</p>	R000000					