

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155307	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
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NAME OF PROVIDER OR SUPPLIER TOWNE CENTRE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7250 ARTHUR BLVD MERRILLVILLE, IN 46410
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F0000	<p>This visit was for the Investigation of Complaint IN00117377.</p> <p>Complaint IN00117377-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F314.</p> <p>Survey date: October 17 & 18, 2012</p> <p>Facility number: 000204 Provider number: 155208 AIM number: 100284910</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 85 Total: 85</p> <p>Census payor type: Medicare: 20 Medicaid: 52 Other: 13 Total: 85</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Preparation and implementation of this plan of correction does not constitute admission or agreement by Towne Centre Health Care of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 10-18-2012. Towne Centre Health Care specifically reserves the rights to move to strike or exclude this document as evidence in any civil, administrative, and criminal action not related directly to the licensing and/or certification of this facility or provider.</p>	
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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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	Quality review completed 10/19/12 Cathy Emswiler RN			

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F0282 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 observation, record review, and interview the facility failed to ensure the resident's plan of care was followed related to limiting the resident's time out of bed for 1 of 3 residents with care plan interventions for limiting time out of bed in the sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>During orientation tour on 10/17/12 at 8:40 a.m., Resident #B was observed sitting in a wheel chair in her room. The resident had Kerlex wrap bandage on both of her feet. The resident was not receiving care from staff at this time.</p> <p>On 10/17/12 at 9:20 a.m. and 10:05 a.m., the resident was observed sitting in a wheel chair in her room. The resident was not receiving care from staff at the above times.</p> <p>On 10/17/12 at 10:25 a.m., the Wound Nurse was observed performing wound care the residents leg wounds. The resident remained sitting up in the wheel</p>	F0282	<p>F Tag 282 Services by Qualified Persons /Per Care Plan 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; a. Resident B-at the time of finding resident B's care plan was reviewed and revised as needed. Resident B's certified nursing assistant help card was revised and updated to reflect current care plan. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; a. All residents were reassessed using Braden Scale to identify residents who are at high /severe risk for pressure sores. Upon completion of assessment care plans were reviewed and updated as needed. Aide care help cards were updated to reflect current care plan. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; a. In Service will be presented to nursing staff (agenda attached). b. Direct care nurses will document every shift that aide has been given report on resident deemed high/severe</p>	11/06/2012

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	<p>chair at this time.</p> <p>On 10/17/12 at 11:25 a.m., the resident was observed sitting in a wheel chair in her room. The resident was not receiving care from staff at this time.</p> <p>On 10/17/12 at 11:45 a.m., the resident was observed sitting in her wheel chair in the Dining Room on the second floor. The resident remained in the Dining Room at 12:16 p.m.</p> <p>On 10/17/12 at 12:51 p.m., the resident was observed sitting in a wheel chair in her room. The resident was not receiving care from staff at this time.</p> <p>On 10/17/12 at 1:10 p.m., the resident was observed in bed. CNA #1 was observed exiting the resident's room at this time. When interviewed at this time, the CNA indicated they had just assisted the resident to bed.</p> <p>The record for Resident #B was reviewed on 10/17/12 at 10/17/12 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia, pressure ulcer, anemia, pneumonia, and osteoporosis. The 9/17/12 MDS (Minimum Data Set) significant change assessment indicated the resident's BIMS (Brief Interview for Cognitive Patterns) score was 2. This</p>		<p>risk for pressure ulcers. c. Direct care nurses will document every shift compliance with pressure ulcer prevention as documented on aide help card. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ; a. Unit Mangers/House Supervisors /Nurse Managers or designee will audit compliance and as long as compliance is achieved, will reduce number of audits: i. Audits will be performed 3x week for 2 months(to include weekend) ii. Audits will be performed 2x week for 2 months (to include weekend) iii. Audits will be performed weekly for 2 months(to include weekend) iv. Audits will be reviewed monthly by Director of Nursing and report will be provided to Q/A committee monthly. v. 100% compliance is expected and this will be ongoing 5. By what date the systemic changes will be completed a. Date Certain November 6, 2012</p>				

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	<p>indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance of two or more staff for transfers.</p> <p>A care plan initiated on 9/11/12 indicated the resident had an alteration in skin integrity as evidenced by pressure ulcers to left foot and right heels. Care plan approaches include for staff to limit the residents time up in the chair. Another care plan initiated on 9/11/12 indicated the resident was dependent on staff for ADL's (Activities of Daily Living). Care plan approaches included for staff to anticipate and provide care for the resident.</p> <p>The CNA assignment care card for Resident #B indicated there was no documentation indicating the resident's time up in the chair was to be limited.</p> <p>When interviewed on 10/17/12 at 2:00 p.m., CNA #1 indicated the resident required a Hoyer lift (mechanical device used to transfer residents) to transfer in and out of bed. The CNA indicated the resident was up in the chair when she started her shift at 6:00 a.m.. CNA #1 also indicated the resident had been transferred out of bed into the chair by the night shift and had not been laid down in</p>				

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	<p>bed until this afternoon as earlier observed.</p> <p>This federal tag relates to Complaint IN00117377.</p> <p>3.1-35(g)(2)</p>			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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 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 interview, the facility failed to ensure a pressure ulcer was covered with dressing as ordered by the Physician for 1 of 4 residents reviewed for pressure ulcers in the sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>On 10/17/12 at 10:10 a.m., Resident #D was observed sitting in wheel chair in her room. The Wound Nurse entered the resident's room to initiate wound care to a pressure ulcer on the resident's coccyx area. The Wound Nurse assisted the resident to a standing position next to the bed and lowered the resident's brief to observe the wound. There was an open wound to the coccyx. The wound measured approximately 3.0 cm (centimeters) x 1.5 cm. There was no dressing over the wound. There was no</p>	F0314	<p>F Tag 314 Treatment/Services to Prevent /Heal Pressure Sores</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>a. Resident D dressing was applied at time of finding</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ;</p> <p>a. All other residents having pressure ulcers were assessed to ensure treatment had been completed and was in place.</p> <p>b. All resident with pressure ulcer treatment physician orders were reviewed to ensure orders were present to apply dressing as ordered and apply prn if soiled or needs replaced.</p> <p>3. What measures will be put in place or what systemic changes will be made to ensure</p>	11/06/2012	

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	<p>dressing observed in the resident's brief or in the seat of the wheel chair.</p> <p>The record for Resident #D was reviewed on 10/17/12 at 9:45 a.m. The resident's diagnoses included, but were not limited to, pressure ulcer, anemia, high blood pressure, diabetes mellitus, congestive heart failure, and depressive disorder.</p> <p>The 10/2012 Physician Order Statement indicated there was an order to cleanse the pressure area to the coccyx with saline, apply Santyl (an ointment used to debride ulcers) and a dry dressing daily until the ulcer was healed.</p> <p>The Weekly Pressure Ulcer Record indicated the Stage III (a wound with full thickness tissue loss) pressure ulcer to the coccyx measured 3 cm x 1.2 cm with a depth of 0.4 cm. Slough (necrotic or avascular tissue in the process of separating from viable tissue) and granulation tissue was noted in the wound and no exudate was observed.</p> <p>When interviewed on 10/17/12 at 10:10 a.m., the Wound Nurse indicated there should have been a dressing in place over the wound as ordered.</p> <p>When interviewed on 10/17/12 the Interim Director of Nursing indicated</p>		<p>that the deficient practice does not recur;</p> <p>a. In Service will be presented to nursing staff (agenda and content attached)</p> <p>b. Direct Care nurse will give report to aide every shift and inform them who has pressure ulcers and to notify the nurse if treatment /dressing is not present when providing care.</p> <p>c. Resident with pressure ulcers will be identified on aide care card with not to notify nurse if dressing/treatment is not in place.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ; The Unit Manager/House Supervisors/Nurse Managers or designee will audit compliance and as long as compliance is achieved, will reduce number of audits as follows:</p> <p>a. Audits will be performed daily every shift for 2 months</p> <p>b. Audits will be performed every shift 3 times a week for 2 months (to include weekends)</p> <p>c. Audits will be performed every shift 2 times a week for 2 months (to include weekend)</p> <p>d. Audits will be reviewed by director of Nursing and reports of findings will be reported to Q/A monthly.</p> <p>e. 100% compliance is expected and monitoring will be</p>		

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	<p>there should have been a dressing in place to the wound.</p> <p>This federal tag relates to Complaint IN00117377.</p> <p>3.1-40(a)(2)</p>		<p>ongoing</p> <p>5. By what date the systemic changes will be completed</p> <p>a. Date Certain November 6, 2012</p>		