

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 04/16/2012
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NAME OF PROVIDER OR SUPPLIER TIMBERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F0000	<p>This visit was for the Investigation of Complaint IN00105699</p> <p>Complaint IN00105699-Substantiated: Federal/State deficiencies related to the allegations are cited at F157 and F309</p> <p>Survey Dates: April 13, and 16, 2012</p> <p>Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830</p> <p>Survey Team: Heather Tuttle, R.N.- T.C. Janelyn Kulik, R.N.</p> <p>Census Bed Type: 132 SNF/NF 132 Total</p> <p>Census Payor Type: 15 Medicare 96 Medicaid 21 Other 132 Total</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>We are requesting paper compliance for survey (IN00105699) Allegation of Credible Compliance. This plan of corection is prepared and executed because it is required by the provision of State and Federal law and not because Timberview Health Care Center agrees with the allegations and citations listed on pages 1-9 of this stagement of deficiency. Timberview Health Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance, please accept May 4, 2012, as our date of compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a deficiency 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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	Quality review completed on April 17, 2012 by Bev Faulkner, R.N.				

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F0157 SS=D	<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> <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 for 1 of 4 residents reviewed with changes in condition related to the removal of a suture from a resident's lip.</p>	F0157	1. As stated in the 2567 regarding resident B after assessing the resident it was determined there were no sutures in the residen'ts lip. Completed investigation which determined	05/04/2012			

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	<p>(Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 4/13/12 at 5:15 a.m. His diagnoses included, but were not limited to, hypertension, cerebrovascular accident (stroke), muscle weakness, psychotic disorder, and pain.</p> <p>A progress note, dated 1/25/12 at 22:30 (10:30 p.m.), indicated the resident was sitting at the nurse's station in a Broda chair, when the chair alarm started to sound. The nurse noted the resident was kicking his legs over the side of the chair. When the nurse attempted to reach the resident the resident was noted falling on the floor. The resident hit his head before the nurse was able to get to the resident. There was blood coming from the resident's mouth. The chair alarm was working properly, the Dycem (pad to prevent slipping) was in place and the resident was wearing non-skid foot wear. The physician and family were notified. At 22:31 (10:31 p.m.), the resident was assessed and the resident's mouth was cleaned with warm water and to find the source of bleeding. The resident's lip was noted to be open in two areas. The physician was informed and a new order was received to send the resident the</p>		<p>that one suture was removed from hospital and one by resident. Wound doctor confirmed upon evaluation that there were not sutures present on 3/21/12 and that the lip had healed. Copy of the physician statement was presented to the state surveyor but not included in the 2567.2. How the facility identified others -- An audit was completed on all residents who have been transferred to the ER and return to facility in the last 30 days. Any issues identified regarding change in condition and treatment will be communicated to the physician and documented in the resident medical record. 3. The system put into place- an in-service will be provided for licensed nurses regarding physician notification and change in condition, assessment, obtaining appropriate physician orders, and follow up documentation. Nurse who identifies change in condition will assess resident, document results of assessment in the medical record and notify the physician. Change of conditions will be discussed in the morning meeting with Administration, nursing, and any issues identified will be addressed as appropriate by disciplinary actions and physician notification.4. How it will be monitored and the quality assurance program: Will monitor by facility management team</p>		

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	<p>Emergency room.</p> <p>A hospital note, dated 1/25/12, indicated a resident with a history of CVA (cerebrovascular accident, stroke) and frequent falls who presented with report of a fall from a chair onto his face. The course of treatment included, but was not limited to, a laceration repair to the interior lower lip with the length of the laceration being 2 cm (centimeters) and a laceration repair to the interior lower lip with the length of the laceration being 1 cm. There was one suture placed in each lacerated area for a total of two sutures.</p> <p>Review of Nursing Progress Notes, dated 1/25/12 and 1/26/12, indicated there was no evidence of any type of documentation or assessment regarding the resident's sutures to his bottom lip. The first and last time Nurse's Notes indicating there were sutures in the resident's lip was on 1/27/12. There was no assessment or documentation regarding the sutures after 1/27/12. Continued review of Nursing Progress Notes from 1/26-2/29/12 indicated the resident's Physician had not been notified of the need to have the sutures removed.</p> <p>Interview with the Director of Nursing (DoN) on 4/16/12 at 9:45 a.m., indicated on March 15 a nurse had informed her</p>		<p>completing an audit of at least 8 residents 5 days a week for 12 weeks, then 3 times a week for 12 weeks and for 6 months total. The audit will monitor for change in condition, physician notification and follow up. This quality assurance program will be coordinated by DON/Designee.</p> <p>5. The completion date will be May 4, 2012.</p>				

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	<p>that Resident #B had a suture in his lip from a previous fall back in January 2012. After assessing the resident, the DoN indicated there were no sutures in the resident's lip. She then completed an investigation into the resident's sutures. She indicated she interviewed the South Unit Manager at the time, who indicated that one day (she could not remember) the resident had pulled a suture out of his lip and handed it to her. The DoN indicated the South Unit Manager did not assess or document any of this information in the resident's record, nor did she call the resident's Physician or notify the resident's family member. Further interview with DoN at the time, indicated the South Unit Manager should had documented the incident in the resident's clinical record and notified the resident's Physician and/or family member. The DoN indicated the South Unit Manager was unavailable for interview</p> <p>Review of the current 1/2012 Physician Notification for change in Condition Policy provided by the DoN indicated the resident's Physician's was to be notified for a change in condition that may warrant a change in current treatment. Physician Notification will be documented in the progress notes, it should contain information regarding the resident condition, Physician notification,</p>						

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	and Physician orders obtained. This Federal tag relates to complaint IN00105699. 3.1-5(a)(2)				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received the necessary care and services for 1 of 4 residents reviewed with a change in condition related to not obtaining orders to remove sutures, not assessing the resident after a suture was removed, and not removing a suture resulting in the resident going to the hospital to have the suture removed. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 4/13/12 at 5:15 a.m. His diagnoses included, but were not limited to, hypertension, cerebrovascular accident (stroke), muscle weakness, psychotic disorder, and pain.</p> <p>A progress note, dated 1/25/12 at 22:30 (10:30 p.m.), indicated the resident was sitting at the nurse's station in a Broda chair, when the chair alarm started to sound. The nurse noted the resident was kicking his legs over the side of the chair.</p>	F0309	<p>1. As stated in the 2567 regarding resident B after assessing the resident it was determined there were no sutures in the resident's lip. Completed investigation which determined that one suture was removed from hospital and one by resident. Wound doctor confirmed upon evaluation that there were not sutures present on 3/21/12 and that the lip had healed. Copy of the physician statement was presented to the state surveyor but not included in the 2567.2. How the facility identified others -- An audit was completed on all residents who have been transferred to the ER and return to facility in the last 30 days. Any issues identified regarding change in condition and treatment will be communicated to the physician and documented in the resident medical record. 3. The system put into place- an in-service will be provided for licensed nurses regarding physician notification and change in condition, assessment, obtaining appropriate physician orders,</p>	05/04/2012			

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	<p>Then the nurse attempted to reach the resident, the resident was noted falling on the floor. The resident hit his head before the nurse was able to get to the resident. There was blood coming from the resident's mouth. The chair alarm was working properly, the Dycem (pad to prevent slipping) was in place and the resident was wearing non-skid foot wear. The physician and family were notified. At 22:31 (10:31 p.m.), the resident was assessed and the resident's mouth was cleaned with warm water and to find the source of bleeding. The resident's lip was noted to be open in two areas. The physician was informed and a new order was received to send the resident the Emergency room.</p> <p>A hospital note, dated 1/25/12, indicated a resident with a history of CVA (cerebrovascular accident, stroke) and frequent falls who presented with report of a fall from a chair onto his face. The course of treatment included, but was not limited to, a laceration repair to the interior lower lip with the length of the laceration being 2 cm (centimeters) and a laceration repair to the interior lower lip with the length of the laceration being 1 cm. There was one suture placed in each lacerated area for a total of two sutures.</p> <p>Review of Nursing Progress Notes, dated</p>		<p>and follow up documentation. Nurse who identifies change in condition will assess resident, document results of assessment in the medical record and notify the physician. Change of conditions will be discussed in the morning meeting with Administration, nursing, and any issues identified will be addressed as appropriate by disciplinary actions and physician notification.4. How it will be monitored and the quality assurance program: Will monitor by facility management team completing an audit of at least 8 residents 5 days a week for 12 weeks, then 3 times a week for 12 weeks for 6 months total. The audit will monitor for change in condition, physician notification and follow up. This quality assurance program will be coordinated by DON/Designee. 5. The completion date will be May 4, 2012.</p>		

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	<p>1/25/12 and 1/26/12, indicated there was no evidence of any type of documentation or assessment regarding the resident's sutures to his bottom lip. The first and last time Nurse's Notes indicating there were sutures in the resident's lip was on 1/27/12. There was no assessment or documentation regarding the sutures after 1/27/12.</p> <p>A hospital note, dated 2/10/12, was provided by the Nurse Consultant on 4/13/12 at 11:00 a.m. The note did not contain any information in regard to the resident's lip.</p> <p>Review of the history and physical from an Emergency Room visit, dated 2/29/12, indicated the resident was sent to the hospital for complaints of chest pain. Upon assessment there was one suture noted in his bottom lip. At that time, while in the emergency room, the resident's lip was sterilely prepped with Betadine and the suture was removed using a suture kit.</p> <p>Further record review indicated there were no physician's orders for the month of January, 2012 or February, 2012 for the removal of the sutures to the resident's lip.</p> <p>Interview with the Nurse Consultant on 4/13/12 at 11:50 a.m., indicated the nurse</p>			

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	<p>should have called the physician and obtained an order to remove the sutures from the resident's lip after he gotten back from the hospital with the sutures. She also indicated there was no order obtained to remove the sutures. She further indicated she knew one of the sutures was removed by a nurse at the facility and one had been removed in the hospital when the resident was sent there; however, she could not remember the days the sutures were removed. The Nurse Consultant then indicated a nurse had removed only one of the sutures but there was no evidence the suture was removed, because it was not documented and the site was not assessed in the resident's clinical record. The DoN was unavailable for interview at this time.</p> <p>Interview with the Director of Nursing (DoN) on 4/16/12 at 9:45 a.m., indicated on March 15 a nurse had informed her that Resident #B had a suture in his lip from a previous fall back in January 2012. After assessing the resident, the DoN indicated there were no sutures in the resident's lip. She then completed an investigation into the resident's sutures. She indicated she interviewed the South Unit Manager at the time, who indicated that one day (she could not remember) the resident had pulled a suture out of his lip and handed it to her. The DoN indicated</p>			

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	<p>the South Unit Manager did not assess or document any of this information in the resident's record, nor did she call the resident's Physician or notify the resident's family member. She indicated the second suture had been removed in the Emergency Room on 2/29/12 (a month later) by the hospital staff. Further interview with DoN at the time, indicated the South Unit Manager should have documented the incident in the resident's clinical record and notified the resident's Physician and/or family member. She further indicated the resident's sutures should have been removed in a more timely manner. The DoN indicated the South Unit Manager was unavailable for interview.</p> <p>This Federal tag relates to complaint IN00105699.</p> <p>3.1-37(a)</p>				