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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155580 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>10/08/2013 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>TIMBERVIEW HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2350 TAFT ST<br>GARY, IN 46404 |
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| F000000            | <p>This visit was for the Investigation of Complaints IN000137120 and IN00137473.</p> <p>Complaint IN00137120 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F332.</p> <p>Complaint IN00137473 - Substantiated. Federal/state deficiency related to the allegations is cited at F406.</p> <p>Survey dates:<br/>October 7 &amp; 8, 2013</p> <p>Facility number: 008505<br/>Provider number: 155580<br/>AIM number: 20064830</p> <p>Survey Team:<br/>Janet Adams, RN, TL<br/>Cynthia Stramel, RN</p> <p>Census bed type:<br/>SNF: 5<br/>SNF/NF: 114<br/>Total: 119</p> <p>Census payor type:<br/>Medicare: 10<br/>Medicaid: 104</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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|   | <p>Other: 5<br/>Total: 119</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on October 21, 2013, by Brenda Meredith, R.N.</p> |   |   |                      |   |

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| F000323<br>SS=D    | <p>483.25(h)<br/>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br/>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure adequate supervision was provided to prevent accidents related to incorrect transfer of a resident for 1 of 3 residents reviewed for accidents in the sample of 9. (Resident #C)</p> <p>Findings include:</p> <p>On 10/8/13 at 8:20 a.m., care of Resident #C was observed. The resident had five distinct marks on her back around her left scapula and axilla. The marks were in an arcing pattern, each mark was approximately 3 to 5 centimeters long. At 11:30 a.m., an observation was made of the resident being transferred with a Hoyer (mechanical) lift. Interview with the CNA #1 at that time indicated they now used the Hoyer lift for transfers. Prior to 9/26/13, they would transfer her manually using two people to hold her under the arms, then stand and pivot. The CNA indicated the Kardex (a form including information on care</p> | F000323       | <p>F323 The facility requests paper compliance for this citation. 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. Immediate actions taken for those residents identified: Resident #C Kardex was updated on 9/26 to reflect Hoyer Lift How the facility identified other residents: New transfer evaluation completed on current residents and Kardex updated as indicated. 3) Measures put into place/ System changes: Nursing staff was re-educated on transfers and use of Kardex CNA's completed competency evaluations on use of mechanical lift and transfers. DON/designee will observe 5 resident transfers per week to ensure proper technique is used. 4) How the corrective actions will be monitored: The</p> | 11/04/2013           |

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|   | <p>measures for each resident) was where resident information was obtained.</p> <p>The record for Resident #C was reviewed on 10/7/13 at 11:00 a.m. Diagnoses included, but were not limited to, dementia, general weakness and aphasia. The 9/9/13 MDS (Minimum Data Set) admission assessment indicated the resident required extensive assistance of two staff members for transfers and bed mobility.</p> <p>A Transfer Evaluation was completed on 9/11/13. The evaluation indicated the resident did not have moderate upper body strength and the ability to follow simple commands. It indicated two staff members were required for bed mobility. The evaluation indicated a total lift was required.</p> <p>A care plan was initiated 1/7/11, for potential for falls. On 9/11/13, the care plan was updated to include use a Hoyer (mechanical) lift and two person assistance for transfers.</p> <p>An Incident Report, dated 9/26/13, indicated the resident had five superficial abrasions to her left scapula, axilla and back varying in length from 6 to 11 centimeters long.</p> |   | <p>results of these observations will be reviewed in the Quality Assurance meeting monthly x3 then quarterly x1 5) Date of compliance: 11/4/13</p> |                      |   |

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|   | <p>The Investigation of Skin Tear, Bruises and Abrasions form, dated 9/26/13, indicated, "Based on appearance and pattern of abrasions, it appears abrasions may have occurred during transfer under arm."</p> <p>The Investigation included written statements from staff members. A statement from CNA #4 indicated, on 9/26/13 at 2:16 a.m., discovered several marks on the resident's back. A written statement, dated 9/26/13, by CNA #2, indicated she and another aide had transferred the resident from the bed into her wheelchair, on 9/25/13 around 3:30 p.m., by, "...two person lifted her under the arms and pivoted her into the chair." No unusual marks were observed. Another written statement (undated) by CNA #3 indicated he had transferred the resident, "safely into bed," later that evening. No unusual marks were observed.</p> <p>Interview with the Nurse Consultant, on 10/8/13 at 3:00 p.m., indicated the transfer evaluation done on 9/11/13 indicated the resident should have been transferred using a mechanical lift. The Nurse Consultant indicated the care plan had been updated at that time to include using a mechanical lift; however the Kardex</p> |   |   |   |  |   |  |

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|                    | <p>had not been updated. She was unable to indicate how the CNA's were to have known the resident required a Hoyer lift for transfers.</p> <p>This federal tag relates to Complaint IN00137120.</p> <p>3.1-45(a)(2)</p> |               |   |                      |

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| F000332<br>SS=D    | <p>483.25(m)(1)<br/>FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br/>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate less than 5 percent (%) for 1 of 6 residents observed during the medication pass. Seven (7) medication errors were observed during 35 opportunities for error in medication administration. This resulted in a medication error rate of 20 %.</p> <p>Findings include:</p> <p>The morning medication pass was observed on 10/8/13 at 7:35 a.m. LPN #3 was standing at the doorway of the room Residents #K and #L both resided in. Resident #L was not in the room at this time. The LPN pointed to Resident #L's name on the name plate on the door and indicated she was going to administer this resident's medications at this time. LPN #3 also stated Resident #L's name out loud.</p> <p>LPN #3 pulled up the computer screen listing the 8:00 a.m. medications ordered for Resident #L. The computer screen listed Resident</p> | F000332       | <p>F332 The facility requests paper compliance for this citation. 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. Immediate actions taken for those residents identified: LPN #3 was immediately removed from resident care, re-educated on "Rights" of medication administration and completed medication pass competency prior to returning to schedule. Resident #K &amp; #L were administered the correct medication. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/ System changes: Licensed staff and QMA's will be re-educated regarding "Rights" of Medication administration. DON/designee will observe medication pass for at least 5 residents per week 4) How the</p> | 11/04/2013           |

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|   | <p>#L's name and room number number and bed number. The LPN then entered the room which both Residents #K and #L resided in. Resident #K was seated in chair next to his bed. The LPN instructed Resident #K she was going to take his blood pressure before administering his medications. The LPN preceded to take the resident's blood pressure. The LPN did not ask or address the resident by name, nor did she attempt to locate an Identification bracelet on the resident. The LPN exited the room after obtaining the Resident #K's blood pressure.</p> <p>LPN #3 then began to remove the following oral medications from the medication cart. All of the following medication were labeled with Resident #L's name and room number on them<br/>Aspirin 81 mg (milligrams)<br/>Clopidogrel 75 mg (a medication to to prevent blood clots)<br/>Ferrex Forte 100 mg (a supplement)<br/>Lisinopril 10 mg (a medication to treat high blood pressure)<br/>Magnesium oxide 400 mg (an electrolyte replacement)<br/>Metoprolol 25 mg (a medication to treat high blood pressure and other cardiac conditions)</p> |   | <p>corrective actions will be monitored: The results of these observations will be reviewed in Quality Assurance meeting monthly x3, then quarterly x1. 5)<br/>Date of compliance: 11/4/13</p> |   |  |   |  |

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|   | <p><b>Thera-M (a multivitamin)</b></p> <p>The LPN placed all the above (7) pills in a medication cup and entered the room shared by Residents #K and #L. Resident #K was still seated a chair next to his bed. LPN #3 approached the resident with the medication cup in her hand and started to hand the to Resident #K. The LPN did not ask the resident his name or check his name ID band prior to starting to hand Resident #K the medications. Resident #K placed his hand out to take the medication cup from the LPN and was asked to return to the medication cart prior to administering the medications to the resident. The resident then stated his name when asked. The resident responded with his name which was Resident #K.</p> <p>LPN #3 then reviewed the computer medication screen and indicated the medications she had prepared and was going to administer to Resident #K were medications ordered for Resident #L.</p> <p>The record for Resident #K was reviewed on 10/8/13 at 12:00 p.m. The resident's diagnoses included, but were not limited to, senile dementia, gout, diabetes mellitus, high blood pressure, chronic airway</p> |   |   |   |  |   |  |

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|   | <p>obstruction, and anemia.</p> <p>The current Physician order for resident #K was reviewed. There were orders for the resident to receive the following medications at 8:00 a.m. daily.</p> <p>Potassium chloride 10 meq (milieu) ( a potassium supplement)</p> <p>Cozaar 100 mg (milligrams) (a cardiac medication)</p> <p>Amolodipine besylate 10 mg (a cardiac medication)</p> <p>Folic acid 1 mg (a vitamin supplement)</p> <p>Colcrys 0.3 mg (a medication to treat gout)</p> <p>Aspirin 81 mg</p> <p>Lasix 40 mg (a diuretic)</p> <p>The facility Medication Administration Pass was completed on 10/8/13 at 8:35 a.m. A total of 35 opportunities for error were observed. A total of (7) errors were observed during the completion of the Medication Administration Pass observation. This resulted in a medication error rate of 20%.</p> <p>The facility policy titled "General Dose Preparation and Medication Administration" was reviewed on 10/8/13 at 10:45 a.m. The policy was dated with the last revision date of</p> |   |   |                      |   |

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|   | <p>5/01/10. The Nurse Consultant provide the policy and identified the policy as current. The policy indicated each time a medication was administered the staff member was to verify that it was the correct medication, the correct dose, the correct route, at the correct time, and for the correct resident.</p> <p>When interviewed on 10/8/13 at 1:00 p.m., the facility Nurse Consultant indicated LPN #3 should have confirmed the residents identity prior to administering them to Resident #K.</p> <p>This federal tag relates to Complaint IN00137120.</p> <p>3.1-25(b)(9)</p> |   |   |                      |   |

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| F000406<br>SS=D   | <p>483.45(a)<br/>PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br/>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation, record review, and interview, the facility failed to ensure rehabilitative services were initiated in a timely manner upon admission to the facility for 1 of 3 resident's reviewed for rehabilitative services upon admission to the facility from the hospital in the sample of 9. (Resident #E)</p> <p>Findings include:</p> <p>During orientation tour on 10/7/13 at 9:32 a.m., Resident #E was observed in bed. There resident was awake and alert.</p> <p>The record for Resident #E was reviewed on 10/7/13 at 10:50 a.m. The resident was admitted to the facility on 9/19/13. The resident was admitted from the hospital. The</p> | F000406   | <p>F406 The facility requests paper compliance for this citation. 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. 1) Immediate actions taken for those residents identified: Resident #E: As stated in the 2567, therapy was initiated on 9/30/13. 2) How the facility identified other residents: Audit was completed of all new admissions since 9/1/13 to ensure therapy orders were received and initiated timely. No other concerns were identified. 3) Measures put into place/ System changes: Interdisciplinary Team</p> | 11/04/2013           |   |

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|   | <p>resident's diagnoses included, but were not limited to, cerebral vascular disease, cerebral vascular accident (stroke), hemiplegia (weakness of an extremity), diabetes mellitus, and high blood pressure.</p> <p>The 9/19/13, Admission/Readmission Data Collection form indicated the residents mobility was very limited (makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently).</p> <p>Review of the 9/2013, Physician orders indicated an order was written, on 9/27/13, for Physical Therapy, Occupational Therapy, and Speech Therapy to evaluate and treat the resident.</p> <p>Review of the 9/28/13, Minimum Data Set (MDS) admission assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (14). This score indicated the resident's cognitive patterns were intact. The MDS assessment also indicated the resident had impairment in range of motion of the upper and lower extremities on both sides.</p> <p>Review of a 8/31/13, hospital History and Physical report indicated the</p> |   | <p>will review all new admissions 5x/week to ensure that therapy orders are received and initiated timely. The Administrator/ designee 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, then quarterly x1. 5) Date of compliance: 11/4/13</p> |                      |   |

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|   | <p>resident was admitted to the hospital on 8/30/13. The report indicated the resident was admitted to the hospital with changes in speech and new right sided weakness.</p> <p>A Pre-Admission Nursing Assessment was completed by the facility Clinical Liaison Nurse, on 9/16/13, in the hospital. The assessment indicated Rehabilitative Services by Physical Therapy and Occupational Therapy were needed. The assessment also indicated the resident required extensive assistance with dressing, bathing, ambulation, and toileting. The assessment also indicated the resident had bilateral lower extremity weakness and required extensive Physical Therapy and Occupational Therapy</p> <p>Review of the 10/1/13, Physical Therapy Evaluation and Plan of Treatment report indicated the start of therapy treatment was 10/1/13. The report indicated indicated the resident had limited functional mobility due to muscle weakness on both lower extremities, poor standing balance, and for functional endurance. The report also indicated the resident required skilled Physical Therapy services to enhance her rehabilitative potential, promote safety awareness,</p> |   |   |   |  |   |  |

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|                    | <p>increase the resident's functional activity tolerance to decrease the resident's level of assistance from caregivers to enhance her quality of life.</p> <p>Review of the 9/30/13, Occupational Therapy Evaluation and Plan of Treatment report indicated the start of therapy treatment was 9/30/13. The report indicated the resident was to receive therapy related to a decrease in functional mobility, decrease in strength, and need for increased assistance from others. The report indicated the resident displayed bilateral upper extremity impairment in range of motion. The report indicated the resident requires skilled Occupational Therapy services to increase independence with ADL's (Activities of Daily Living), increase strength, and her overall functional endurance. The report also indicated the resident was at risk for further decline in function.</p> <p>The 10/5/13, Physician Progress Note indicated the resident was admitted to the facility post CVA (stroke) for rehabilitation and long term care. The note also indicated the resident complained of left arm and shoulder weakness.</p> |               |   |                      |

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|   | <p>A Grievance/Concern Form was initiated on 9/30/13. The form indicated the resident's sister called the Social Worker and stated the resident wanted to be discharged if she did not receive therapy.</p> <p>When interviewed, on 10/8/13 at 12:12 p.m., the Clinical Liaison Nurse indicated she completed the Pre-Admission Nursing Assessment for the resident during the resident's hospitalization. The Nurse indicated the resident had a diagnosis of CVA (stroke). The Nurse indicated she reviewed the resident's hospital records and was able to observe and talk with the resident at this time. The Nurse indicated the resident displayed weakness. The Nurse also indicated her assessment indicated the resident the would require Physical and Occupational Therapy upon admission to the facility.</p> <p>When interviewed, on 10/8/13 at 12:30 p.m., the Therapy Manager indicated the resident began receiving Physical and Occupational therapies on approximate dates of 9/30/13 or 10/1/13. The Therapy Manager indicated she received a list of resident's with care plans that needed to the reviewed or signed a few days prior to the start of the resident's</p> |   |   |   |  |   |  |

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|   | <p>therapy. The Therapy Manager indicated at that time she noted the resident had been a new admission and was not on Therapy caseload and this is when it was determined the resident was to be evaluated for skilled therapies.</p> <p>When interviewed, on 10/8/13 at 12:10 p.m., Social Worker #1 indicated the resident's son and and the resident's sisters husband were at the facility to discuss discharge plans for the resident. The Social Worker indicated she thought the resident was admitted to the facility from the hospital for rehabilitation.</p> <p>When interviewed, on 10/8/13 at 9:40 a.m., Social Worker #2 indicated she spoke with the resident's sister on 9/30/13 related to sister voicing concerns that the resident wanted to leave the facility as she did not understand why therapy was not started. The Social Worker she then spoke with the Therapy Department staff and they informed her the resident started receiving therapy the day before. The Social Worker also indicated a Grievance form was completed related to the above concern voiced by the resident's sister.</p> |   |   |                      |   |

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|   | <p>When interview, on 10/8/13 at 9:40 p.m., LPN #1 indicated she believed that Social Service had received a call from the resident's family acquiring about preparing for the resident's discharge and this is when the facility found out she had not received therapy.</p> <p>This federal tag relates to Complaint IN00137473.</p> <p>3.1-23(a)(1)</p> |   |   |                      |   |