

| | | | |
|--|---|--|---|
| 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 02/12/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|------------------------|--|---------------|---|----------------------|
| F 0000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 8, 9, 10, 11, and 12, 2016.</p> <p>Facility number: 000541 Provider number: 155475 AIM number: N/A</p> <p>Census bed type: SNF: 13 Residential: 187 NCC: 46 Total: 246</p> <p>Census payor type: Medicare: 12 Other: 47 Total: 59</p> <p>Sample: Residential: 11 NCC: 5</p> <p>These deficiencies reflect state finding cited in accordance with 410 IAC 16.2-3.1.</p> | F 0000 | | |

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.

| | | | |
|--|---|--|---|
| 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 02/12/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|----------------------------|--|---------------|---|----------------------|
| F 0157 SS=D Bldg. 00 | <p>QR completed on 2/15/16 by 17934.</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> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> | | | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| 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 02/12/2016 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>Based on interview and record review, the facility failed to ensure the Physician was notified prior to administering Ectotrin (aspirin) for 1 resident who was allergic to aspirin.</p> <p>This deficiency affected 1 of 1 resident who was reviewed for an aspirin allergy (Resident #20).</p> <p>Findings include:</p> <p>On 2/8/16 at 2:53 P.M. Resident #20 declined an interview saying she was itchy and had asked the nurse for some medicine for the itching.</p> <p>The record of Resident #20 was reviewed on 2/9/16 at 3:01 P.M. and had diagnosis including, but not limited to, aftercare following joint replacement surgery and osteoarthritis right shoulder.</p> <p>There was a Physician's Order dated 1/14/16 for Resident #20 for Ecotrin 325 milligrams (mg) give 1 tablet daily for 30 days.</p> <p>The Discharge Orders from the local hospital dated 1/14/16 indicated Resident #20 was allergic to aspirin.</p> <p>The Medication Administration Record for January 2016 indicated the Ecotrin</p> | F 0157 | <p>F157 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. As noted in the finding, there was communication with the family regarding the possible allergy to aspirin, and the family indicated that she was not allergic to the medication. The aspirin was discontinued and there was no evidence that the hives that the resident was experiencing was related to the medication. The pharmacy is in the process of auditing all resident charts to assure that there are no additional residents that are receiving medications that they have a known allergy. In addition, the pharmacy is conducting an in-service training program with the nursing staff regarding medications and allergies. The pharmacy will continue in the future to review medication orders and compare those orders with known allergies. The nursing staff will also receive training on notifying the physician when there are medications that have been ordered and an allergy is noted to that medication. A review of medications and allergies will be included in the quarterly risk management (QA Meeting) meeting, to monitor compliance. The Director of Nursing and Administrator will monitor. Completion date: March 13, 2016</p> | 03/13/2016 | | | |

| | | | |
|--|---|--|---|
| 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 02/12/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>325 mg was signed as given from 1/17 through 1/28/16.</p> <p>An interview with the Director Of Nursing (DON) on 2/10/16 at 9:30 A.M. indicated the admitting nurse RN #1 noted on the discharge orders from the hospital that Resident #20 was allergic to aspirin and called a family member because the aspirin was ordered for the resident. The DON indicated the family member indicated it was ok to give the resident the aspirin. The DON indicated RN #1 had also spoken with Resident #20 and the resident had told RN #1 it was ok to give the aspirin because the hives the resident had were not related to the aspirin. The DON indicated 1 week later RN #2 had observed the resident was allergic to aspirin and had called a different family member and the aspirin was discontinued by the Physician. The DON also indicated the resident had the hives prior to administering the aspirin in the first place and the resident had also indicated the aspirin could cause some swelling in her mouth.</p> <p>An Interdisciplinary Note dated 1/28/16 at 16:50 (4:50 P.M.) documented by RN #2 indicated Resident #20 "...10 a (10:00 A.M.) Pt (patient) requested medication to help with hives, lip swollen and right side of tongue swollen, staff administered</p> | | | |

| | | | |
|--|---|--|---|
| 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 02/12/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>visteral (antihistamine used to treat hives and itching)...Pt returned from therapy and stated she was having some trouble swallowing...Physician (Physician's name) on call for (Resident #20's Physician) (Physician's name) notified (sic) said to monitor pt, use prn (as needed) epi pen (epinephrine) (used to treat allergic reactions) if needed in emergency and send to hospital. Dr (Physician's name) (endocrinologist) notified, no new orders and have (Resident #20's Physician's name) see pt tomorrow. (On call Physician) ordered for lisinopril to be d/c'd (discontinued) said swollen tongue can be side effect of lisinopril and wants (Resident #20's Physician name) to review meds (medications) and maybe put her on a different b/p (blood pressure) med, but (family member) does not want this med d/c'd said this is the only b/p med that works well for her so following up with (Resident #20's Physician's name) tomorrow. (Family member) also wants pt to stop taking Ecotrin said she has an allergy to this medication...."</p> <p>The Policy "Physician Notification Procedure /Family/POA/ Administrative Personnel revised August 2014, received from the DON on 2/11/16 at 11:15 A.M. indicated "...Procedure: 4. A need to alter treatment significantly (i.e. a need to</p> | | | |

| | | | | | |
|--|--|---|---|----------------------|---|
| 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 02/12/2016 |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 0329 SS=D Bldg. 00 | <p>discontinue an existing form of treatment due to adverse consequences"</p> <p>A document received from the DON dated 2/11/16 at 8:30 A.M. indicated RN #1 failed to notify the resident's Physician when RN #1 initially found the resident was allergic to aspirin.</p> <p>3.1-5(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review,</p> | F 0329 | F329 The Towne House does not agree with this finding. However, | 03/13/2016 | |

| | | | | | |
|--|---|---|---|----------------------|---|
| 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 02/12/2016 |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>the facility failed to ensure the Physician was notified prior to administering Ectotrin (aspirin) for 1 resident who was allergic to aspirin.</p> <p>This deficiency affected 1 of 1 resident who was reviewed for an aspirin allergy (Resident #20).</p> <p>Findings include:</p> <p>On 2/8/16 at 2:53 P.M. Resident #20 declined an interview saying she was itchy and had asked the nurse for some medicine for the itching.</p> <p>The record of Resident #20 was reviewed on 2/9/16 at 3:01 P.M. and had diagnosis including, but not limited to, aftercare following joint replacement surgery and osteoarthritis right shoulder.</p> <p>There was a Physician's Order dated 1/14/16 for Resident #20 for Ecotrin 325 milligrams (mg) give 1 tablet daily for 30 days.</p> <p>The Discharge Orders from the local hospital dated 1/14/16 indicated Resident #20 was allergic to aspirin.</p> <p>The Medication Administration Record for January 2016 indicated the Ecotrin 325 mg was signed as given from 1/17 through 1/28/16.</p> | | <p>as part of the certification process, this plan of correction has been developed to meet the requirements of the program. As noted in the finding, there was communication with the family regarding the possible allergy to aspirin, and the family indicated that she was not allergic to the medication. The aspirin was discontinued and there was no evidence that the hives that the resident was experiencing was related to the medication. The pharmacy is in the process of auditing all resident charts to assure that there are no additional residents that are receiving medications that they have a known allergy. In addition, the pharmacy is conducting an in-service training program with the nursing staff regarding medications and allergies. The pharmacy will continue in the future to review medication orders and compare those orders with known allergies. The nursing staff will also receive training on notifying the physician when there are medications that have been ordered and an allergy is noted to that medication. A review of medications and allergies will be included in the quarterly risk management (QA Meeting) meeting, to monitor compliance. The Director of Nursing and Administrator will monitor. Completion date: March 13, 2016</p> | | |

| | | | |
|--|---|--|---|
| 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 02/12/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--|--|--|--|--|
| | <p>An interview with the Director Of Nursing (DON) on 2/10/16 at 9:30 A.M. indicated the admitting nurse RN #1 noted on the discharge orders from the hospital that Resident #20 was allergic to aspirin and called a family member because the aspirin was ordered for the resident. The DON indicated the family member indicated it was ok to give the resident the aspirin. The DON indicated RN #1 had also spoken with Resident #20 and the resident had told RN #1 it was ok to give the aspirin because the hives the resident had were not related to the aspirin. The DON indicated 1 week later RN #2 had observed the resident was allergic to aspirin and had called a different family member and the aspirin was discontinued by the Physician. The DON also indicated the resident had the hives prior to administering the aspirin in the first place and the resident had also indicated the aspirin could cause some swelling in her mouth.</p> <p>An Interdisciplinary Note dated 1/28/16 at 16:50 (4:50 P.M.) documented by RN #2 indicated Resident #20 "...10 a (10:00 A.M.) Pt (patient) requested medication to help with hives, lip swollen and right side of tongue swollen, staff administered visteral (antihistamine used to treat hives and itching)...Pt returned from therapy</p> | | | |
|--|--|--|--|--|

| | | | |
|--|---|--|---|
| 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 02/12/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>and stated she was having some trouble swallowing...Physician (Physician's name) on call for (Resident #20's Physician) (Physician's name) notified (sic) said to monitor pt, use prn (as needed) epi pen (epinephrine) (used to treat allergic reactions) if needed in emergency and send to hospital. Dr (Physician's name) (endocrinologist) notified, no new orders and have (Resident #20's Physician's name) see pt tomorrow. (On call Physician) ordered for lisinopril to be d/c'd (discontinued) said swollen tongue can be side effect of lisinopril and wants (Resident #20's Physician name) to review meds (medications) and maybe put her on a different b/p (blood pressure) med, but (family member) does not want this med d/c'd said this is the only b/p med that works well for her so following up with (Resident #20's Physician's name) tomorrow. (Family member) also wants pt to stop taking Ecotrin said she has an allergy to this medication...."</p> <p>The Policy "Physician Notification Procedure /Family/POA/ Administrative Personnel revised August 2014, received from the DON on 2/11/16 at 11:15 A.M. indicated "...Procedure: 4. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences"</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 02/12/2016 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| R 0000 Bldg. 00 | 3.1-48(a)(4) Towne House Retirement Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. | R 0000 | | | |