

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 08/26/2013
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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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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit also included the investigation of Complaint IN00130038.</p> <p>Complaint IN00130038-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 19, 20, 21, 22, 23, & 26, 2013</p> <p>Facility Number: 000204 Provider Number: 155307 AIM Number: 100284910</p> <p>Survey Team: Lara Richards, RN-TC Cynthia Stramel, RN Yolanda Love, RN Janelyn Kulik, RN (8/19/13)</p> <p>Census bed type: 76 SNF/NF 76 Total</p> <p>Census payor type: 16 Medicare 50 Medicaid 10 Other 76 Total</p>	F000000	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 8-26-2013. 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.	

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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 2, 2013, by Janelyn Kulik, RN.</p>				

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F000226 SS=C	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure contracted service providers were informed annually of the Elder Justice Act and Reporting a Reasonable Suspicion of a Crime. This had the potential to affect the 76 residents residing in the facility.</p> <p>Findings include:</p> <p>Interview with the Administrator on 8/26/13 at 1:30 p.m., indicated when the Elder Justice Act went into effect several years ago, her contracted service providers were informed. She indicated the facility had the same contract providers, therefore, they had not been informed annually of the Elder Justice Act. She also indicated the information related to the Elder Justice Act was posted throughout the facility.</p> <p>The facility policy titled "Elder Justice Act Crimes Reporting" dated 10/15/12 and identified as current, was provided by the Administrator. The</p>	F000226	F226 1) Letters will be sent to all agents and contractors regarding their reporting obligations under the Elder Justice Act. Owners, Operators, employees and managers have been notified annually. 2) All residents have the potential to be affected. 3) Facility will no longer be in operation as of 11-4-2013, so no such system will be necessary. 4) Facility will no longer be in operation as of 11-4-2013, so no QAA will be necessary to assure notification is made annually. 5) Letters will be sent by 9-25-2013.	09/25/2013	

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	<p>policy and procedure was reviewed on 8/26/13 at 2:00 p.m. The policy indicated the following: "It is the policy of the facility to notify owners, operators, employees, managers, agents, and contractors (collectively referred to as "Covered Individuals" and individually as a "Covered Individual") of their duty to report reasonable suspicions of crimes against facility residents to the Indiana State Department of Health and one local law enforcement agency, and to otherwise comply with the requirements of the Elder Justice Act regarding reporting of reasonable suspicions of crimes." Facility responsibilities included, but were not limited to, "Annually notify all Covered Individuals of their reporting obligations under the Elder Justice Act to report a suspicion of a crime to the Indiana State Department of Health and local law enforcement for the political subdivision in which facility is located."</p> <p>3.1-28(a)</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each resident's dignity was maintained during dining observed in the assist dining room regarding 1 of 8 residents being called "sweetie" (#20) and 1 of 8 residents being assisted by a CNA who remained standing (#38).</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 8/19/13 at 12:06 p.m., Activity Aide #1 was observed offering residents coffee and cocoa in the Assist dining room. The Activity Aide referred to Resident #20 as "sweetie". On 8/20/13 at 8:30 a.m., the Staff Development Coordinator was observed giving new employees a tour of the building. When walking past the Assist dining room, the Staff Development Coordinator referred to the dining room as the "feeder" dining room. On 8/22/13 at 7:45 a.m. Resident #38 was observed in the Assist dining 	F000241	<p>F241 1) An apology has been rendered to Resident #20 to referring to her as "sweetie". The SDC has been educated as to proper referral to the dining room identified will be referred to as "The Small Dining Room". The CNA #1 has been re-educated on proper techniques when assisting residents with meals. 2) Interviewable residents will be asked if they have been referred to as "sweetie" or other terms of endearment. Apology will be rendered immediately. Same residents will also be asked if they have heard the Small Dining Room ever referred to as other than that and if so, apology will again be rendered. All residents will be assisted with their meals by staff who are seated. Nursing staff will be re-educated as to need to refrain from using terms of endearment, using term "feeders", and will be instructed to remain seated while assisting resident with meals. 3) All staff will be in-serviced on Resident Dignity and use of terms of endearments and use of the term "feeders". CNAs will be in-serviced proper techniques for assisting residents during meals.</p>	09/25/2013			

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	<p>room. The resident was seated in a broda chair. At this time, CNA #1 was observed standing over the resident while she was assisting her with her meal. A chair was located behind the CNA.</p> <p>Interview with Nurse Consultant #1 on 8/22/13 at 10:30 a.m., indicated the residents should be called by their name and the Assist dining room should not be referred to as the "feeder" dining room. Further interview on 8/26/13 at 4:55 p.m., indicated staff should not stand while assisting the residents with their meals.</p> <p>3.1-3(t)</p>		<p>4) Small Dining Room will be audited for one meal per day for 2 weeks, then one meal per week for remaining time any resident are remaining due to facility closure. 100% compliance will be expected for each audit. Any acts of non-compliance will be corrected immediately by auditor.</p> <p>5) 9-25-2013</p>				

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F000278 SS=B	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to oral/dental status and range of motion for 2 of 25 MDS assessments reviewed. (Residents #7 and</p>	F000278	F278 1) Resident #7 has been re-assessed and referred to a dentist and MDS has been corrected. Resident #51 has had finger re-assessed and MDS corrected to reflect correct assessment. 2) All current resident MDSs will be reviewed to assure assessments are correct and corrections to MDS will be	09/25/2013	

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	<p>#51)</p> <p>Findings include:</p> <p>1. On 8/20/13 at 11:16 a.m., Resident #7 was observed with a loose tooth on her bottom teeth.</p> <p>Interview with the resident on 8/20/13 at 11:10 a.m., indicated some of her teeth on the bottom were loose and some teeth on top were broken and she needed to get them pulled.</p> <p>The record for Resident #7 was reviewed on 8/22/13 at 9:00 a.m. Review of the Annual Minimum Data Set (MDS) assessment dated 7/30/13, indicated Section L Oral/dental status was blank.</p> <p>Interview with the MDS Coordinator on 8/26/13 at 11:15 a.m., indicated the resident's dental section was not completed related to information about the resident's teeth not being available. She indicated the Unit Managers were to make the assessments and relay the information to her.</p> <p>2. On 8/21/13 at 8:25 a.m., Resident #51 was observed participating in an activity. The resident was not able to fully extend the index finger on his left</p>		<p>made upon discovery of the incorrect assessment. 3) MDS nurses will be in-serviced on coding accuracy and procedure for obtaining information or performing assessment to assure information in present and accurate when MDS is due. 4) MDS will be reviewed for accuracy by MDS Coordinator prior to submission. Nurse consultant will audit one MDS weekly to assure complete and accurate coding occurred prior to submission. This will be ongoing through facility closure on 11-4-2013. 5) 9-25-2013.</p>		

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	<p>hand.</p> <p>The record for Resident #51 was reviewed on 8/21/13 at 1:55 p.m. The resident's diagnosis included, but was not limited to, osteoarthritis.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 7/1/13, indicated the resident had no functional limitations in range of motion to both sides of the upper extremities.</p> <p>Interview with the MDS Coordinator on 8/26/13 at 11:15 a.m., indicated the resident had arthritis and that was why he was not fully able to extend his index finger on the left hand. She indicated functional limitation in range of motion to the upper extremity should have been coded on the MDS.</p> <p>3.1-31(g)</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 observation, interview and record review, the facility failed to ensure the plan of care was followed as written related to the monitoring of bruises for 1 of 3 residents reviewed for bruising out of the 6 residents that met the criteria for skin conditions non-pressure related. The facility also failed to monitor the blood pressure of a resident receiving blood pressure medication for 1 of 3 residents reviewed for hospitalization of the 5 residents who met the criteria for hospitalization. (Residents #9 and #117)</p> <p>Findings include:</p> <p>1. On 8/22/13 at 11:47 a.m., the closed record for Resident #117 was reviewed. Diagnoses included, but were not limited to, hypertension and congestive heart failure.</p> <p>A Care Plan dated 6/20/13, indicated the problem of risk for hypo/hypertension (low or high blood pressure). The approaches included to monitor blood pressure, administer</p>	F000282	F282 1) Resident #117 no longer residents at facility. Resident #9 has been properly assessed for bruising and care plan has been updated. 2) Medication Administration Records (MARS) have been reviewed to determine if other Blood Pressure medications that require monitoring have been taken. Skin Assessments on all current residents have been performed to determine if properly documented. 3) Unit Manager/designee will monitor MARSdaily for any missing documentation. Licensed nurses will be in-serviced on proper Blood Pressure monitoring and skin documentation. 4) Director of Nursing/designee will audit MARS and Skin Sheets weekly for duration of facility remaining open to assure compliance through Closure date of 11-4-2013. 5) 9-25-2013.	09/25/2013			

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	<p>blood pressure medication as ordered by the Physician and to notify Physician of abnormal findings.</p> <p>The Medication Administration Record (MAR) for July 2013, indicated the following medications and instructions:</p> <p>Torseamide (a blood pressure medication) 20 milligram (mg) tablet, give one tablet daily, hold if blood pressure less than 90/60. Amlodipine besylate (a blood pressure medication) 5 mg tablet, give one tablet daily, hold if blood pressure less than 90/60. Hydrochlorothiazide (a diuretic) 25 mg tablet, give one tablet daily, hold if blood pressure less than 90/60.</p> <p>The July 2013 MAR, indicated the Torsemide, Amlodipine and Hydrochlorothiazide had been given on July 1, 2, 3 and 4. There were no blood pressures documented on the MAR for those dates. There were no blood pressures documented in the Nursing progress notes for those dates as well.</p> <p>Interview with LPN #1 on 8/23/13 at 9:02 a.m., indicated it was her initials on the MAR and she gave the resident her medication on July 1, 2</p>						

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	<p>and 3. She indicated she had taken the resident's blood pressure on those dates, but did not document it in the record.</p> <p>Interview with the Director of Nursing on 8/26/13 at 2:25 p.m., indicated the blood pressures should have been taken and documented for this resident daily.</p> <p>2. Observation on 8/20/13 at 9:26 a.m., indicated Resident #9 had multiple areas of reddish bruising to the right and left arms. On 8/21/13 at 12:54 p.m., the resident was observed in her wheelchair across from the Nursing station. The reddish bruising remained to the resident's right and left arms.</p> <p>The record for Resident #9 was reviewed on 8/21/13 at 8:20 a.m. Review of the Resident Care Plan dated 7/24/13, indicated the resident was at risk for alterations in skin integrity. Resident had a history of bruises, received Coumadin, and a history of skin cancer. Nursing approaches included, but were not limited to, observe skin with care.</p>			

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	<p>Review of the Resident Care Plan dated 7/25/13, indicated the resident was at risk for hemorrhage and bruising. Resident received Coumadin, propelled self, and very independent on unit and in room. Nursing approaches included, observe for abnormal bruising, encourage to be aware of extremities when going through doorways and tight spaces, obtain labs as ordered.</p> <p>Review of the Weekly Skin Integrity Review sheet dated 8/20/13, indicated skin intact, there was no documentation related to bruising.</p> <p>Review of the Nurses' Notes indicated, the last entry date was 8/17/13, there was no documentation related to bruising.</p> <p>Interview with LPN #2 on 8/21/13 at 1:34 p.m., indicated documentation should have been completed related to the bruising and monitored for 72 hours.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 observation, record review, and interview, the facility failed to ensure an ongoing assessment of bruises was completed for 1 of 3 residents reviewed for bruising of the 6 residents who met the criteria for skin conditions non-pressure related. (Resident #9)</p> <p>Findings include:</p> <p>Observation on 8/20/13 at 9:26 a.m., indicated Resident #9 had multiple areas of reddish bruising to the right and left forearms that were 1 centimeter (cm) x 1 cm in size.</p> <p>On 8/21/13 at 12:54 p.m., the resident was observed in her wheelchair across from the Nurses' station. The reddish bruising remained to the resident's right and left arms.</p> <p>The record for Resident #9 was reviewed on 8/21/13 at 8:20 a.m. The resident's diagnoses included, but</p>	F000309	<p>F309 1) Resident #9 has been re-assessed the bruises have been properly documented. 2) All residents will have skin checked 2 times weekly by licensed nurse. 3) Nursing staff will be re-educated by 9-25-2013 to report bruises as identified while providing care per Interact Tools. 4) 24-hour reports are reviewed M-F in morning nurses meeting and on weekend by Nurse Manager to audit for presence of proper documentation. Any failure to document bruising will be 5) 9-25-2013</p>	09/25/2013

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	<p>were not limited to, Alzheimer's, dementia, and skin cancer. Review of the Resident Care Plan dated 7/24/13, indicated the resident was at risk for alterations in skin integrity. The resident had a history of bruising, received Coumadin, and a history of skin cancer. Nursing approaches included, but were not limited to, observe skin with care.</p> <p>Review of the Resident Care Plan dated 7/25/13, indicated the resident was at risk for hemorrhage and bruising. The resident received Coumadin, propelled herself, and was very independent on the unit and in her room. Nursing approaches included, but were not limited to, observe for abnormal bruising, encourage resident to be aware of extremities when going through doorways and tight spaces, and obtain labs as ordered.</p> <p>Review of the Weekly Skin Integrity Review sheet dated 8/20/13, indicated skin intact, there was no documentation related to bruising.</p> <p>Review of the Nurses' Notes indicated the last entry was dated 8/17/13. There was no documentation related to bruising.</p>			

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 08/26/2013
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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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	<p>Interview with the Wound Care Nurse on 8/21/13 at 9:16 a.m., indicated non pressure skin issues were to be documented in the Nurses' Notes and monitored for three days when they are initially observed.</p> <p>Interview with LPN #2 on 8/21/13 at 12:54 p.m., indicated skin assessments were completed on shower days and the resident's shower days were Tuesday and Friday. She also indicated the CNA's call the nursing staff into the shower room to complete the skin assessment and then documentation was completed on the Weekly Skin Integrity Review sheet. She then reviewed the resident's Weekly Skin Integrity Review sheet dated 8/20/13 and verified there was no documentation indicating bruising.</p> <p>Interview with LPN #2 on 8/21/13 at 1:34 p.m., indicated documentation should have been completed related to the bruising and monitored for 72 hours.</p> <p>After the interview was completed, a Weekly Skin Integrity Review sheet was initiated on 8/21/13 which indicated the resident had bruising to her arms which were red in color. The following measurements were</p>			

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	<p>documented for the bruises: 1 cm x 1.2 cm, 0.4 cm x 0.3 cm, 0.4 cm x 0.6 cm, and 1.8 cm x 0.4 cm.</p> <p>3.1-37(a)</p>			

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F000327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 residents reviewed for hydration was monitored for dehydration. (Resident #34)</p> <p>Findings include:</p> <p>The record for Resident #34 was reviewed on 8/23/13 at 10:03 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's, urinary tract infection, and depression.</p> <p>A Physician's order dated 11/12/12 and listed on the August 2013 Physician's order summary (POS), indicated the resident was to have a Basic Metabolic Profile (BMP) every 3 months.</p> <p>A 11/12/12 Hydration worksheet, indicated the resident scored a "4" which was moderate risk for dehydration. There was no additional review of the hydration worksheet until 8/3/13.</p> <p>Prior to 8/3/13, the resident did not</p>	F000327	F327 1) Resident #34 is now hydrated per tube feeding so meal intake record no longer recorded by CNAs. 2) Meal intake records for all resident have been reviewed for proper fluid intake and/or any missing documentation to determine if any resident are at risk for dehydration. A hydration assessment will be completed on all residents by 9-25-2013. 3) Nursing staff will be in-serviced on proper documentation for meal records. 4) Meal intake records will be audited daily for one week, then 3 times per week for remainder of time facility remains in operation until 11-4-2013. Any missing entries will be investigated to determine if resident is dehydrated. 5) 9-25-13	09/25/2013			

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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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	<p>have a care plan indicating that she was at risk for dehydration.</p> <p>Review of the laboratory results dated 7/2/13, indicated the resident's BUN (blood urea nitrogen) was elevated at 35 (normal results 6-26) and her Creatinine was elevated at 1.6 (normal results 0.5-1.0). BUN and Creatinine levels are indicators of the resident's hydration status as well as kidney functions.</p> <p>An entry in the Nursing progress notes dated 7/2/13 at 3:15 p.m., indicated the Physician was faxed and notified of the lab results. No new orders were received at that time.</p> <p>Documentation in the Nursing progress notes on 7/16/13 at 1:05 p.m., indicated the Nurse was called to the resident's room due to the resident was leaning to the right side and said she did not know what was wrong. The Physician was called and no new orders were received. The Nurse requested if a urinalysis and culture and sensitivity could be checked. The Physician indicated no new orders and to monitor the resident's status. At 4:00 p.m., the resident was verbally responsive but lethargic. Documentation at 11:00 p.m., indicated the resident was</p>				

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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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	<p>voiding dark yellow urine.</p> <p>An entry in the Nursing progress notes dated 7/17/13 at 3:15 a.m., indicated the resident stated, "I just don't feel okay." The resident was unable to make the Nurse aware of what symptoms she had. Staff indicated they would continue to monitor.</p> <p>Documentation in the Nursing progress notes dated 7/20/13 at 7:00 p.m., indicated the resident's appetite was poor and she required one assist with activities of daily living.</p> <p>An entry in the Nursing progress notes dated 7/23/13 at 1:30 p.m., (the first entry since 7/20/13) indicated "the resident's skin was cool/clammy to touch, blood sugar at 11:45 a.m. was 185. Sliding scale given per order, noon meal no intake, drank small sips of apple juice, would let juice fall out of mouth. Blood sugar after lunch at 1:15 p.m. was 286. Blood pressure was 90/64 (normal 120/80). Lung sounds diminished. Spoke with Physician at office he stated, "resident has history of ESBL (organism in urine), monitor for fever and for drop in blood pressure, put in bed for now." Call Physician "back in one hour, I will decide what to do</p>			

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	<p>then." At 1:40 p.m., the resident was in bed, call light in reach. Skin cool/clammy, temperature 96.8 axillary. Incontinent of urine, no foul odor noted. At 2:00 p.m., temperature 95.7 axillary, blood pressure 88/54, pulse 68, respirations 12, skin cold and clammy. Lungs diminished all lobes. Resting in bed, no restlessness noted. At 2:30 p.m., temperature 95.7, blood pressure 76/46, pulse 76, respirations 12. Cold/clammy. Lungs diminished. Spoke with Physician, order received to send to Emergency room, spoke with daughter, in agreement with Physician to send to Emergency room." At 2:40 p.m., 911 was called. The resident was admitted to the hospital with the diagnoses of shock and severe dehydration.</p> <p>Review of the Resident Meal Intake Record for the month of July 2013, indicated 7/16/13-7/19/13, the resident's intake for breakfast, lunch, and dinner was less than 25%. Her fluid intake averaged between 4 and 8 ounces at each meal. There was no documentation of the resident's food and fluid intake for breakfast and lunch on 7/20 and 7/21/13. On 7/22 and 7/23/13 the resident's food and fluid intake for breakfast and lunch was less than 25% and 4 ounces of</p>				

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	<p>fluid was consumed. Documentation on 7/23/13 indicated the resident consumed less than 25% for dinner and consumed 8 ounces of fluid. The resident was in the hospital at this time.</p> <p>Interview with Nurse Consultant #1 on 8/26/13 at 8:55 a.m., indicated an IV had been suggested by Nursing staff on 7/16/13 to the Physician and he declined as well as the family. She indicated this was not documented in the resident's record. Continued interview at the time also indicated the Resident Meal Intake Record for the weekend prior to the resident being sent out was incomplete.</p> <p>Interview with Nurse Consultant #1 on 8/26/13 at 3:00 p.m., indicated there was no additional hydration assessment after 11/12/12.</p> <p>3.1-46(b)</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to male staff not wearing beard guards and food stored without labels. This had the potential to affect 76 residents in the facility who received oral diets out of a total population of 76 residents.</p> <p>Findings include:</p> <p>During the Kitchen Sanitation Tour on 8/19/13 at 8:56 a.m., with the Dietary Food Manager, the following were observed:</p> <ol style="list-style-type: none"> Chopped and diced onions stored in zipped bags in the walk in refrigerator were not labeled. Interview with the Dietary Manager at the time, indicated there was no label on the bags of onions. Three male staff members were observed without beard guards. 	F000371	<p>F371 1) The bag of onions were discarded at the time of survey. The Dietary staff who had facial hair and not wearing beard guards were instructed to immediately put guards in place. 2) All residents have the potential to be affected. All items in the walk-in refrigerator have been assessed for proper labeling and any items discovered without proper labeling have been discarded. Staff members identified not wearing beard guards have been reprimanded. 3) In-services will be provided to all dietary staff involved in food storage as to proper procedure for labeling stored food, and for proper use of beard guards. 4) Dietary Manager/designee will observe for proper use of beard guards at every meal every day. This will be on-going through the final day of facility operation on 11-4-2013. Any missing beard guards will be put on immediately and employee will receive disciplinary action. 5) 9-25-2013</p>	09/25/2013	

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	<p>Interview with Dietary Manager on 8/26/13 at 1:40 p.m., indicated there were 3 male staff members present in the kitchen at the time without beard guards.</p> <p>3.1-21(i)(3)</p>			

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to ensure expired insulin vials were not in use for 1 of 4 insulin dependent diabetics who resided on the First floor. (Resident #42)</p> <p>Findings include:</p> <p>On 8/26/13 at 10:40 a.m., a vial of Levemir insulin was observed in the First floor medication cart for Resident #42. The vial was dated as being opened on 7/9/13. There was a sticker on the vial that indicated the insulin was not to be used after</p>	F000425	<p>F425 1) Expired insulin has been discarded for resident #42. 2) All insulin has been audited to assure no other expired vials. Any expired vials have been discarded. 3) Nurses will be in-serviced by 9-25-2013 on facility Policies for expired insulins. Oncoming nurse will review expiration date prior to administering insulin. 4) Unit Manager/designee will audit all insulin for expiration dates once per week for the duration of the facility operation until closure on 11-4-2013. 5) 9-25-2013.</p>	09/25/2013	

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	<p>8/7/13. There was also an orange sticker on the vial which indicated the insulin was to be discarded after 42 days, which would have been 8/20/13.</p> <p>The record for Resident #42 was reviewed on 8/26/13 at 2:14 p.m. The resident's diagnosis included, but was not limited to, diabetes. A Physician's order dated 7/9/13, indicated the resident was to receive Levemir 16 units subcutaneously nightly at 9:00 p.m.</p> <p>Review of the August 2013 Medication Administration Record (MAR), indicated the Levemir had been signed out as given 8/21/13-8/25/13.</p> <p>Interview with LPN #3 at the time, indicated she would have to get clarification on what date the medication should have been discarded.</p> <p>Review of the "Insulin Storage Recommendations" provided by the Director of Nursing on 8/26/13 at 2:30 p.m., and identified as being current, indicated the following: Levemir insulin should be discarded 42 days after being opened.</p>			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	F441 1) The bed pans have been removed and properly	09/25/2013			

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	<p>maintain an infection control program related to isolation procedures. The facility also failed to ensure bedpans were stored properly on 1 of 2 units throughout the facility. This had the potential to affect 76 of the 76 residents residing in the facility. (Residents #60 and #132 and the First floor)</p> <p>Findings include:</p> <p>1. On 8/19/13 at 9:00 a.m., during the Initial Tour of the facility, there were no isolation rooms observed.</p> <p>Interview with the Infection Control Nurse on 8/26/13 at 8:39 a.m., indicated when isolation precautions were needed for a resident, staff were notified verbally through shift report and family notified by phone. They did not use signs on the residents' doors to alert visitors of isolation precautions or use isolation carts. She indicated they used Universal Precautions, including gloves that were available in the residents' room. She further indicated gowns were available in central supply if deemed necessary, but had not been used to her knowledge in the past year. She agreed that visitors did not have any way of knowing the status of a resident.</p>		<p>stored for resident #60 and #132. 2) All resident bathrooms have been reviewed for proper storage of bed pans. All residents with known infections have been reviewed for proper infection control practices in place. Any bed pans not properly stored have been removed. Any residents requiring Isolation precautions not already in place will be implemented immediately. 3) Nursing staff will be re-educated on facility Infection Control program including proper storage of bed pans. 4) Resident bathrooms will be audited weekly by the Unit Manager/designee for proper storage of bed pans. Infection Control Nurse/designee will review all new diagnoses of infections per 24-hour Report Monday through Friday and Nurse Manager on Saturday and Sunday. This will be ongoing through the facility closure 11-4-2013. 5) 9-25-2013</p>				

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	<p>Interview with LPN #1 on 8/26/13 at 9:35 a.m., indicated she normally worked on the C hall of the second floor and there had been no one on isolation precautions for "at least 8 months" on that hall. She indicated they did not use signs on resident doors, and that isolation carts were kept in the resident bathrooms and red bio-bags for soiled items were kept in the isolation cart. She was unable to say how visitors would be alerted to isolation status.</p> <p>Interview with the Director of Nursing (DoN) and Nurse Advisor (NA) on 8/26/13 at 9:55 a.m., indicated a sign would be put on the resident's door if isolation precautions were necessary to alert staff and visitors. She indicated c.diff (clostridium difficile, a contagious intestinal condition) as an example of a disease that would warrant contact isolation precautions. She also indicated an isolation cart was kept in the hallway outside the resident's room. The DoN indicated red bio-bags were kept in the utility room for soiled items. Further interview indicated the NA and DoN agreed there were inconsistencies in the isolation policy and that further staff education may be necessary.</p>			

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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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	<p>The Infection Control book was reviewed on 8/26/13 at 10:20 a.m. There was an Individual Infection Report dated 8/19/13 for Resident #60. This resident had c.diff and was on antibiotic therapy from 8/17/13 through 8/24/13. Another Individual Infection Report was dated 8/5/13 and indicated Resident #132 was on antibiotic therapy from 8/5/13 through 8/19/13. The section of the reports, "Were Precautions Required to Prevent Transmission?", was left blank.</p> <p>The Infection Control Policy was received from the DoN on 8/26/13 at 9:00 a.m., and identified as current. The Policy indicated, "...17. The facility shall assure that necessary training, equipment and supplies are available to carry out an effective Infection Control Program..."</p> <p>2. On 8/19/13 at 11:35 a.m., in Room 1106, an uncovered bedpan was observed in the shower stall of the shared bathroom. Two residents resided in this room.</p> <p>On 8/26/13 at 11:50 a.m., in Room 1106, an uncovered bedpan was observed in the shower stall of the shared bathroom. Two residents resided in this room.</p>			

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	<p>Interview with the Unit Manager at that time, indicated bedpans should be wrapped in plastic when not in use, she was unaware of the bedpan in that shower stall and removed it.</p> <p>3.1-18(b)(2)</p>			

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F000463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure call lights were properly functioning for 2 of 13 resident rooms on the A hall of the Second floor. This had the potential to affect the 39 residents residing on the Second floor. (Rooms 1204 and 1207)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 8/20/13 at 7:53 a.m., the call light for Bed A in Room 1204 was observed to not work properly. The light would not stay on when the button was pressed. The Unit Manager was notified at that time and agreed it was not working correctly. Two residents resided in this room. On 8/20/13 at 8:04 a.m., the call light for Bed B in Room 1207 was observed to not work correctly. The light would not stay on when the button was pressed. Two residents resided in this room. <p>3.1-19(u)(1)</p>	F000463	<p>F463 1) Resident Call systems for rooms 1204 and 1207 were repaired at time of survey. 2) All rooms have been audited for properly functioning call lights. No other rooms have been identified as having improperly functioning call lights. 3) Maintenance Staff will audit 10 rooms per week for properly functioning call lights and make any necessary corrections immediately. Nursing staff will be in-serviced on procedure for notifying maintenance staff of any non-functioning call lights. 4) Administrator will review audit sheets of Maintenance staff weekly to verify all Call Lights audited have been repaired and are in working order. Any lights discovered not functioning will be referred to the Executive Director for proper repair/replacement. These audits will continue until facility closure 11-4-2013. 5) 9-25-2013</p>	09/25/2013			

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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained related to marred walls, chipped plaster, and missing trim on 2 of 2 units throughout the facility. This had the potential to affect the 76 residents residing in the facility. (The First and Second floors)</p> <p>Findings include:</p> <p>On 8/26/13 at 1:10 p.m., during the Environmental Tour with the Maintenance Supervisor, the following were observed:</p> <p>a. In Room 1118, there was cracked and chipped plaster on the wall near the closet door. One resident resided in this room.</p> <p>b. In Room 1204, there was a hole at the base of the wall next to the closet trim and the edge of the wall was scratched and marred. Two residents resided in this room.</p> <p>c. In Room 1211, the bathroom door had a hole on the inside and there</p>	F000465	<p>F465 1) a) Cracked and chipped plaster has been repaired in room #1118. b) The hole in the wall and the scratches and marring on the wall of room 1204 have been repaired. c) The bathroom door and wall of room 1211 have been repaired. d) The marred walls and the bathroom door scratches and mars have been repaired in room 1216. e) The area around the outlet for the AC in room 1217 has been repaired. f) The missing trim has been replaced in room 1219. 2) All rooms in Health Care will be reviewed for scratches, marring, holes and missing trim by the Executive Director/designee. Any items in need of repair or replacement will be corrected by 9-25-2013. 3) Maintenance Staff will perform rounds of rooms monthly until 11-4-2013 until facility ceases to operate. 4) Facility will cease to operate on 11-4-2013, so no QA will be implemented for ongoing compliance. 5) 9-25-2013</p>	09/25/2013

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	<p>were mars on the wall next to the closet. One resident resided in this room.</p> <p>d. In Room 1216, the walls by the bathroom door were marred. The bathroom door was scratched and marred. One resident resided in this room.</p> <p>e. In Room 1217, the plaster wall was cracked and sunken next to the outlet for the air conditioner. One resident resided in this room.</p> <p>f. In Room 1229, there was a missing piece of trim on the bathroom wall. Two residents resided in this room.</p> <p>3.1-19(f)</p>						