

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  02/13/2014
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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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F000000	<p>This visit was for the Investigation of Complaints IN00144034, IN00144168, IN00144315 and IN00144336.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/18/13.</p> <p>This visit was in conjunction to the Post Survey Revisit (PSR) to the Investigation of Complaints IN00140612 and IN00141984 completed on 1/3/14.</p> <p>Complaint IN00144034 - Substantiated. Federal/State deficiencies related to the allegations are cited at F310 and F385.</p> <p>Complaint IN00144168 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00144315 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00144336 - Substantiated. No deficiencies related to the allegations are cited.</p>	F000000	<p>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.</p>	

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>Unrelated deficiencies cited.</p> <p>Survey dates: February 11, 12 and 13, 2014</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Cynthia Stramel, RN, TC Yolanda Love, RN Heather Tuttle, RN 2/13/14 Lara Richards, RN 2/13/14</p> <p>Census bed type: SNF: 13 SNF/NF: 122 Total: 135</p> <p>Census payer type: Medicare: 23 Medicaid: 105 Other: 7 Total: 135</p> <p>These deficiencies reflect State findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 20, 2014, by Janelyn Kulik,</p>						

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F000282 SS=D	<p>RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to ensuring anti-contracture devices were in place for 1 of 3 residents reviewed for range of motion (ROM). (Resident #62)</p> <p>Findings include:</p> <p>On 2/12/14 at 1:40 p.m., Resident #62 was observed laying in her bed. Her hands were contracted, she was not wearing a splinting device.</p> <p>On 2/13/14 at 10:30 a.m., the resident was observed laying in her bed, she was not wearing a splinting device on her hands. She had a splinting device on her right knee.</p> <p>The resident's record was reviewed</p>	F000282	<p>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 #62 was referred to therapy for re-evaluation on 2/14/14 for contracture and splint management. 2) How the facility identified other residents: Audit was completed of all residents with orders for anti-contracture devices to ensure devices were applied as ordered. 3) Measures put into place/ System changes: Nursing staff will be re-educated regarding application of</p>	03/02/2014	

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	<p>on 2/13/14 at 10:00 a.m. The resident was readmitted to the facility on 10/10/13. The Resident's diagnoses included, but were not limited to, cerebral vascular accident (CVA) and quadriplegia.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 1/13/14, indicated the resident was rarely or never understood, was dependant for personal hygiene and dressing, and required extensive two person assistance for bed mobility.</p> <p>A Care Plan updated 12/18/13 indicated the problem of contracture management. The goal was to provide contracture management through the next review. Approaches included direct care staff to apply palm protectors in the morning and remove after lunch.</p> <p>Interview with Restorative Aide #1 on 2/13/14 at 10:30 a.m., indicated she did not apply the palm protectors during care. She would provide range of motion exercises to the residents legs and apply the knee splint. She indicated the CNA's were supposed to apply the palm protectors for the resident.</p> <p>Interview with CNA #1 on 2/13/14 at</p>		<p>anti-contracture devices per physician orders and plan of care. · Observation rounds will be completed on at least 5 residents with anti-contracture devices per day 5x/week and will be verified by 2 nursing managers to ensure compliance. Resident #62 will be included in observations at least 5x/week.</p> <p>· The Director of Nursing and Restorative Nurse 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 months, then quarterly x1 for a total of 6 months. · Staff non-compliant with plan of correction will be disciplined up to and including termination.</p>		

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	<p>11:00 a.m., indicated she was routinely assigned to care for Resident #62 and was familiar with her. She indicated the Restorative Aide applied the palm protectors, she indicated she had never applied palm protectors to that resident. Review of the residents Kardex (CNA care plan) at that time indicated direct care staff was to apply palm protector before breakfast and remove after lunch. The CNA indicated she was not aware of that item on the Kardex.</p> <p>3.1-35(g)(2)</p>			

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F000310 SS=D	<p>483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a functional commutation system was provided for 1 of 1 residents reviewed for language barriers related to not providing translation services for a Spanish speaking resident and ensuring the necessary care and services were provided to maintain the highest psychosocial well being. (Resident #D)</p> <p>Findings include:</p> <p>On 2/11/14 at 6:55 p.m., during an initial tour of the facility with LPN #4, Resident #D was observed in his room laying in bed. LPN #4 identified the resident as being alert and oriented with periods of confusion, Spanish speaking, and totally dependent on staff to provide</p>	F000310	<p>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 #D was re-evaluated for communication needs with staff and care, and socialization stimulation. 2) How the facility identified other residents: No other residents were identified in building with a language barrier. 3) Measures put into place/ System changes: All staff will be re-educated on assisting resident with having Television on appropriate channel or radio on Hispanic channel. Communication cards are</p>	03/02/2014	

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	<p>his care needs. At this time there was a family member noted in the resident's room.</p> <p>On 2/11/14 at 8:20 p.m., the resident was observed in his room laying in bed. There were no visitors noted in the room at this time, nor were there any observations of the television or radio being on. There was also no evidence of picture cards at the resident's bedside.</p> <p>On 2/12/14 at 11:25 a.m., the resident was observed in his room laying in bed. There were no visitors noted in the room at this time, nor were there any observations of the television or radio being on. There was also no evidence of picture cards at the resident's bedside.</p> <p>On 12/12/14 at 2:00 p.m., the resident was observed in his room laying in bed. The resident's son was observed visiting with the resident.</p> <p>On 2/13/14 at 8:30 a.m., the resident was observed in his room laying in bed. There were no visitors noted in the room at this time, nor were there any observations of the television or radio being on. There was also no evidence of picture</p>		<p>available to appropriate staff. · Observation rounds audit will be completed 5 times a week to assure appropriate communication is available. · The Administrator and Social Service Director 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 months, then quarterly x1 for a total of 6 months.</p>				

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	<p>cards at the resident's bedside.</p> <p>On 2/13/14 at 9:00 a.m., the resident was observed in his room laying in bed. The resident's caregiver was in the room, the call light was also noted to be on.</p> <p>On 2/13/14 at 3:35 p.m., the resident was observed in his room laying in bed. There were no visitors noted in the room at this time, nor were there any observations of the television or radio being on. Interview with CNA #5 indicated the resident's picture cards were not at the resident's bedside. Further review indicated the picture cards were located in a box at the nursing station.</p> <p>The record for the resident was reviewed on 2/12/14 at 11:20 a.m. The resident was admitted to the facility on 12/19/13. The resident's diagnoses included, but were not limited to, dementia without behavior disturbances, chronic kidney disease, chronic pain, hypertension, and depressive disorder.</p> <p>The Admission Minimum Data Set (MDS) Assessment dated 12/26/13, indicated the resident had a Brief Interview for Mental Status (BIMS)</p>				

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	<p>score of 14, indicating he was alert and oriented. The resident's functional status indicated he was totally dependent for transfers. The interview for Activity Preferences indicated it was very important for him to have books, newspapers, and magazines to read. It also indicated it was very important for him to listen to the music he likes, and somewhat important for him to participate in his favorite activities and to do things with groups of people. The MDS also indicated the resident received Speech Therapy 3 days a week, Occupational Therapy 5 days a week, and Physical Therapy 5 days a week which began on 12/20/13.</p> <p>A care plan dated 12/23/13 indicated the resident had a language barrier that limits participation to group activities. The goal indicated the resident will be invited to activities that are less dependent on language through the next review date. The interventions included, but were not limited to, honor choices, praise any level of involvement, utilize family member to obtain interest, and to review calendar and to explain specific program content.</p> <p>Review of the Multi-Disciplinary Fall Screen report dated 1/27/14</p>				

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	<p>indicated, the resident had a fall on 1/26/14 at 8:30 p.m. The writer was called to the resident's room by another nurse. The resident was observed on the floor laying on his right side with his back towards the door. The resident was laying between the left side of the bed and the wall near the window. The writer also indicated the resident was speaking Spanish and she didn't understand what he was saying. She also indicated the resident was alert but unable to effectively communicate needs due to language barrier.</p> <p>Interview with Social Service Employee #1 and #2 on 2/12/14 at 2:35 p.m., indicated the facility was utilizing communication/picture cards, family participation, and communication boards to overcome the communication barrier between the staff and the resident. They also indicated there were no Spanish speaking staff available in the facility and the staff anticipates the resident's needs as they would a non-verbal resident.</p> <p>Interview with LPN #4 on 2/12/14 at 10:42 a.m., indicated the resident does not speak English and was not able to converse. She also</p>			

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	<p>indicated it was very hard to communicate with the resident unless the caregiver was in the building to translate.</p> <p>Interview with the Physical Therapist (PT), Occupational Therapy Assistant (OTA) and Speech Therapist (ST) on 2/12/13 at 1:50 p.m., the PT and OTA indicated it was difficult to communicate with the resident. The PT indicated he knows a small amount of Spanish and would communicate with the resident with a picture board and/or through repeat demonstration. The ST indicated the resident was discharged from therapy due to his swallowing goal being met, she also indicated the resident had a language and literacy barrier and the therapy provided was not able to meet those needs.</p> <p>Interview with the resident's son on 2/12/13 at 2:20 p.m., indicated he and his family visited everyday. The resident's son indicated the resident was confused at that time. He indicated when the resident was at baseline, he would tell him he was scared to be left alone because no one understood him. The son indicated family would visit everyday to provided socialization to the</p>				

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	<p>resident. The son had no concerns related to the care the resident received.</p> <p>Interview with the DoN, ADoN, and the Administrator on 2/12/14 at 2:40 p.m., indicated they felt the facility was providing appropriate care for the resident despite the language/communication barrier. They indicated the resident's needs are anticipated by utilizing gestures, facial recognition, and communication boards/picture cards. They also indicated the family and caregiver were in the facility daily and they were utilizing them as a source of communication, which the family agreed to on admission. When asked how they were meeting the resident's psychosocial needs they indicated the family provided the resident with socialization daily. They also indicated the resident had a television and radio in his room.</p> <p>Interview with the Activity Aide #3 on 2/13/14 at 10:00 a.m., indicated the resident was independent with social activities and he enjoyed watching television in his room and listening to music. She also indicated the resident had not attended any group activities due to a recent infection</p>						

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F000318 SS=D	<p>that required isolation. The resident was not currently on isolation.</p> <p>This Federal tag relates to Complaint IN00144034.</p> <p>3.1-37(a)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure a resident received appropriate treatment for contractures to prevent further decrease in range of motion for 1 of 3 residents reviewed for range of motion. (Resident #62)</p> <p>Findings include:</p> <p>On 2/12/14 at 1:40 p.m., Resident #62 was observed laying in her bed.</p>	F000318	<p>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 #62 was referred to therapy for</p>	03/02/2014

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	<p>Her hands were contracted, she was not wearing a splinting device.</p> <p>On 2/13/14 at 10:30 a.m., the resident was observed laying in her bed, she was not wearing a splinting device on her hands. She had a splinting device on her right knee.</p> <p>The resident's record was reviewed on 2/13/14 at 10:00 a.m. The resident was readmitted to the facility on 10/10/13. The resident's diagnoses included, but were not limited to, cerebral vascular accident (CVA) and quadriplegia.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 1/13/14 indicated the resident was rarely or never understood, was dependant for personal hygiene and dressing, and required extensive two person assistance for bed mobility.</p> <p>A Care Plan updated 12/18/13 indicated the problem of contracture management. The goal was to provide contracture management through the next review. Approaches included direct care staff to apply palm protectors in the morning and remove after lunch.</p> <p>Interview with Restorative Aide #1</p>		<p>re-evaluation on 2/14/14 for contracture and splint management. 2) How the facility identified other residents: Audit was completed of all residents with orders for anti-contracture devices to ensure devices were applied as ordered. 3) Measures put into place/ System changes: Nursing staff will be re-educated regarding application of anti-contracture devices per physician orders and plan of care. Observation rounds will be completed on at least 5 residents with anti-contracture devices per day 5x/week and will be verified by 2 nursing managers to ensure compliance. Resident #62 will be included in observations at least 5x/week. The Director of Nursing and Restorative Nurse 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 months, then quarterly x1 for a total of 6 months. Staff non-compliant with plan of correction will be disciplined up to and including termination.</p>				

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	<p>on 2/13/14 at 10:30 a.m., indicated she did not apply the palm protectors during care. She would provide range of motion exercises to the residents legs and apply the knee splint. She indicated the CNA's were supposed to apply the palm protectors for the resident.</p> <p>Interview with CNA #1 on 2/13/14 at 11:00 a.m., indicated she was routinely assigned to care for Resident #62 and was familiar with her. She indicated the Restorative Aide applied the palm protectors, she indicated she had never applied palm protectors to that resident. Review of the residents Kardex (CNA care plan) at that time indicated direct care staff was to apply palm protector before breakfast and remove after lunch. The CNA indicated she was not aware of that item on the Kardex.</p> <p>3.1-42(a)(2)</p>				

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F000385 SS=D	<p>483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN</p> <p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>Based on interview and record review the facility failed to ensure Physician services were available for a resident related to the delay in Physician notification of an alert lab value for 1 of 3 resident's reviewed for Physician/family notification. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 2/13/14 at 8:30 a.m. The resident was admitted to the facility on 6/11/13. The resident's diagnoses included, but were not limited to, cerebral vascular accident (CVA), anemia and renal disease.</p> <p>The Annual Minimum Data Set (MDS) Assessment dated 11/5/13 indicated the resident was dependant for ADL's (activity of daily</p>	F000385	<p>1) Immediate actions taken for those residents identified: Resident #B had subsequent labs drawn on 1/28/14 and 2/12/14 which showed improvement in hemoglobin. 2) How the facility identified other residents: Audit was completed of all residents with phoned alert lab values in last 14 days and untimely physician response. 3) Measures put into place/ System changes: Nursing staff will be re-educated regarding timely notification of MD and timely response from MD on alert labs. Nurse is to notify Primary Care Physician x 3 and if no response then notify Medical Director/Co-Medical Director. If no response from Medical Director/Co-Medical Director then nurse is to notify DON. Audit will be completed daily in clinical meeting weekly x 4, monthly x2 then quarterly x1. The Director of Nursing/Designee will be responsible for oversight of these audits. 4) How the</p>	03/02/2014			

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	<p>living) assistance and was rarely or never understood.</p> <p>A Nursing note dated 1/14/14 at 7:49 p.m., indicated the Medical Director was contacted regarding abnormal lab results for the resident. The Medical Director ordered the CBC and CMP (blood test) to be repeated in the morning on 1/15/14. The residents primary Physician had been paged 4 times that evening at 3:45 p.m., 4:15 p.m., 4:45 p.m. and 6:45 p.m. and did not return the page.</p> <p>The Laboratory results indicated the resident's blood was collected on 1/15/14 at 4:10 a.m. The Laboratory results indicated at 2:35 p.m., a lab technician notified LPN #1 by phone and fax at the facility that the resident's Hemoglobin was 7.8, which was an alert lab value. Nursing notes for 1/15/14 were reviewed, there was no documentation of an alert lab value being received.</p> <p>Interview with LPN #1 on 2/13/14 at 12:20 p.m., indicated she did not recall receiving notification on 1/15/14 of an alert lab value related to the low Hemoglobin for Resident #B.</p>		<p>corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p>		

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	<p>Nursing note dated 1/16/13 at 4:30 p.m., indicated the facility had received the results from 1/15/14, which included an alert value related to low Hemoglobin. The primary Physician was paged.</p> <p>The primary Physician was paged again on 1/16/14 at 5:50 p.m., 6:53 p.m., 9:15 p.m. and 10:30 p.m. with no return calls.</p> <p>The Medical Director was paged on 1/16/14 at 5:50 p.m. and 6:53 p.m. The evening Nursing Supervisor was notified at 5:50 p.m. of the situation.</p> <p>There were no further documented attempts to contact the Physician or Medical Director until 1/17/14 at 2:45 p.m. The Medical Director was contacted at that time and notified of the lab results. He ordered the lab test to be repeated on the following Monday.</p> <p>Interview with the Director of Nursing (DoN) on 2/13/14 at 11:30 a.m., indicated Nurses are expected to make 3 or 4 attempts to contact the primary Physician, then they should contact the Medical Director. If Medical Director was not available, they should contact the co-Medical</p>						

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	<p>Director. She indicated she was not aware of the above events with Resident #B, and she was not the Supervisor called that evening. She indicated the Supervisor should assist the nurse to contact a Physician in such a situation. She further indicated the delay in reaching a Physician was not acceptable.</p> <p>Review of the policy titled Physician/Family/Responsible Party Notification for Change in Condition dated 8/2013, was received from the Nurse Consultant on 2/13/14 at 11:35 a.m. The policy indicated the purpose was to ensure medical care problems were communicated to the attending Physician and family in a timely, efficient and effective manner. Items included that required notification included abnormal labs or diagnostic findings.</p> <p>This Federal tag relates to Complaint IN00144034.</p> <p>3.1-22(a)(2)</p>						

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