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 07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	2350 TAFT ST GARY, IN 46404

(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
F000000	This visit was for the Investigation of Complaints IN00128277, IN00129429, and IN00131667, and IN00132618. Complaint IN00128277-Substantiated. Federal/state deficiency related to the allegations is cited at F502. Complaint IN00129429-Substantiated. Federal/state deficiency related to the allegations is cited at F282. Complaint IN00131667-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00132618-Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiency cited. Survey dates: July 25 & 26, 2013 Facility number: 008505 Provider number: 155580 AIM number: 200064830	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Survey team: Janet Adams, RN, TC Janelyn Kulik, RN (July 26, 2013) Census bed type: SNF: 11 SNF/NF: 124 Total: 135 Census payor type: Medicare: 12 Medicaid: 113 Other: 10 Total: 135 Sample: 14 These deficiencies reflect state findings in accordance with 410 IAC 16.2. Quality Review completed on July 31, 2013, by Brenda Meredith, R.N.			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on record review and interview, the facility failed to ensure Physician's orders were followed related to foot care treatments ordered by the Podiatrist for 1 of 3 residents reviewed for Podiatry visits in the sample of 14. (Resident #D) Findings include: The closed record for Resident #D was reviewed on 7/25/13 at 1:20 p.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, altered mental status, and joint stiffness. The resident was discharged from the facility on 6/7/13. The 5/2013 Treatment Administration Records were reviewed. The following Physician orders were noted on the 5/2013 Treatment Administration Record: 5/13/13-Right great toe: Mix one 1 capful of Betadine solution with 2 quarts of warm water, soak with the	F000282	**F282 The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · Unable to correct deficiency for Resident #D, was discharged from facility on 6/7/13. **2) How the facility identified other residents:** · Review of treatment orders received since 7/26/13 to ensure orders were transcribed and administered as ordered. **3) Measures put into place/ System changes:** · Licensed staff will be educated regarding verification, transcription and clarification of written physician orders. · Written physician orders will be reviewed 5x/week for accurate transcription and clarification as	08/23/2013

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	dressing on to loosen the dressing, remove the dressing, and soak for another 15 minutes. Apply Neosporin ointment (an antibiotic ointment), cover with a gauze pad, gauze tube, and secure twice day. The start date of the order was 5/13/13, and the D/C (discontinue) date was 5/20/13. This treatment was signed out as completed twice a day 5/13/13 through 5/19/13. 5/21/13- Right great toe: Mix 1 capful of Betadine solution with 2 quarts of warm water, soak with dressing on to loosen, then remove dressing and soak for another 15 minutes, apply Neosporin ointment, and cover with a dry dressing daily. The start date of the order was 5/21/13. There was no D/C date. This treatment was signed out as completed twice day on 5/21/13, 5/22/13, 5/24/13, 5/26/13, 5/29-5/31/13. The treatment was signed out as completed once a day 5/23/13, 5/25/13, 5/27/13, and 5/28/13. The 6/2013 Treatment Administration Records were reviewed. The following Physician orders were noted on the 6/2013 Treatment Administration Record: Right great toe: Mix 1 capful of		indicated. · DON/designee will be responsible for oversight of these audits. **4) How the corrective actions will be monitored:** · The results of these audits will be reviewed in Quality Assurance Meeting monthly x3, then quarterly x1 for a total of 6 months. **5) Date of compliance: 8/23/13**	

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	Betadine solution with 2 quarts of warm water, soak with dressing on to loosen, then remove dressing and soak for another 15 minutes, apply Neosporin ointment, and cover with a dry dressing daily. The start date of the order was 5/21/13. There was no D/C date. This treatment was signed out as completed twice a day on 6/1/13 - 6/6/13. The 5/2013 and 6/2013 Nursing Progress Notes were reviewed. An entry made on 5/2/13 at 5:59 p.m. indicated the resident returned from the foot doctor appointment with new instructions to soak feet twice a day. An entry made on 5/9/13 at 1:01 p.m. indicated the resident returned with her family from an appointment. The entry also indicated orders were to continue the treatment to the resident's right great toe. An entry made on 5/20/13 at 12:24 p.m. indicated the resident returned from an appointment with new orders to now change the treatment to the right great to daily. When interviewed on 7/26/13 at 11:28 a.m., the facility Director of Nursing indicated there was a prescription written by the Podiatrist on 5/20/13. The Director of Nursing indicated the order on the prescription			

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	noted the treatment was to be completed daily. The Director of Nursing indicated the treatment should have been completed once a day from 5/21/13 through 6/6/13 as ordered by the Physician. This federal tag relates to Complaint IN00129429. 3.1-35(g)(2)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a resident was assessed after an accident occurred for 1 of 2 residents reviewed for accidents in the sample of 14. (Resident #E) Findings include: On 7/26/13 at 8:45 a.m. Resident #E was observed sitting in a chair in the dining room. He was sleeping and leaning to the left side of his chair. At this time CNA #5 indicated the resident did not ambulate and when the staff assisted him they used a wheelchair. She further indicated when he tried to walk with staff at times it was like his legs gave out on him. On 7/26/13 at 11:15 a.m. the resident was sitting in the dining room during activities with a snack in front of him. The record for Resident #E was reviewed on 7/26/13 at 9:08 a.m. The resident's diagnoses included, but	F000323	**F323 The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · As indicated in the 2567, Resident #E was sent to hospital for evaluation, investigation was completed, and Nurse #5 was suspended and disciplinary action taken on 5/16/13. **2) How the facility identified other residents:** · Review of Risk Management Reports (Incident Reports) in last 30 days to ensure progress note, assessment, MD notification and neurological checks were completed as indicated. **3) Measures put into place/ System changes:** · Licensed	08/23/2013

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	were not limited to, altered mental status, muscle weakness, difficulty walking, cardiovascular disease, hypertension (high blood pressure), chronic obstruction pulmonary disease, cachexia (malnutrition), Alzheimer's disease, and depression. A Nursing Progress Note, dated 5/16/13 at 12:01 p.m., indicated the resident was observed to have swelling to the left side of his face and cheek. When touched, the resident had no verbal or observed complaints of pain or discomfort. His sclera (white part of the eye) were white with no indication of irritation or trauma. The area was firm to touch and had some redness noted. The resident had no other bruising or swelling noted to his skin. The Physician was notified of the situation. A new order was received to send the resident to the Emergency Room for evaluation and treatment. Further review of the Nursing Progress Notes indicated there was no documentation for the resident on 5/15/13. A care plan initiated on 9/30/10 indicated the resident had limited physical mobility related to generalized weakness. The		staff and CNA's will be educated regarding procedure for incident reporting including notifying licensed nurse and nursing manager of incident at time of occurrence. · Licensed staff will be educated regarding post-incident assessment to be completed including neurological checks as indicated, documentation, and physician notification. · Risk Management reports will be reviewed 5x/week to ensure appropriate assessment, notification and documentation are completed as indicated. · DON/ designee is responsible for oversight of these audits. **4) How the corrective actions will be monitored:** · The results of these audits will be reviewed in Quality Assurance Meeting monthly x3, then quarterly x1 for a total of 6 months. **5) Date of compliance: 8/23/13**	

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	interventions included, but were not limited to, the resident required extensive assist (resident involved in activity with staff providing weight bearing support) from staff for mobility. Review of the Annual Minimum Data Set Assessment (MDS), dated 4/22/13, indicated the resident was totally dependent (activity provided by staff) for bathing with one staff assist. Review of the Quarterly MDS Assessment, dated 7/22/13, indicated the resident was totally dependent for bathing with one staff assist. A Fall Assessment dated 5/15/13 indicated the resident's score was 13. A score of 13 indicated the resident was at high risk for falls. Review of a Reportable Incident Form, provided by the Director of Nursing on 7/26/13, indicated an incident occurred on 5/15/13 at 8:30 p.m. Resident #E was being given a shower and slipped and hit his face on the wall. There were two CNA's assisting him. The injury noted was redness and swelling to the left side of his face and it was noted on 5/16/13. The Physician was notified and the resident was sent to the			

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	Emergency Room. The facility was attempting to contact the resident's family. The Five Day Follow Up report to the incident indicated the resident was diagnosed with a contusion, x-rays were negative, and the resident would be screened by Physical Therapy. The follow up report also indicated the resident was to continue to have two CNA's with him in the shower. A written statement from CNA #6 dated 5/16/13 (no time), indicated she was in the shower with CNA #7 last night giving Resident #E and another resident showers. As Resident #E stood up there was water on the floor, the resident slipped and bumped his face really hard on the wall in the shower room. The CNA's told the Nurse. She indicated further that both of the CNA's saw swelling on the resident where he had bumped the wall. A written statement by CNA # 7 dated 5/16/13 (no time), indicated on 5/15/13 she and CNA #6 were showering two male residents. Upon standing, Resident #E bumped his face on the wall while being transferred from the wheel chair to the shower chair. As she continued			

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	to shower the resident she pulled the call light for the Nurse. Nurse #5 entered and was informed of what had happened. A Counseling/Corrective Action form, dated 5/16/13, indicated Nurse #5 was suspended pending investigation due to an infraction that occurred on 5/15/13. Resident #E hit his face in the shower last evening, the two CNA's stated they told the Nurse of the incident and there was no incident report initiated, no neurological checks (assessments to evaluate for any changes in neurological status) initiated, or documentation on the resident. The resident was sent to the Emergency Room today, 5/16/13, for evaluation of facial deformity. Nurse #5 indicated she went to the shower room and did not hear the CNA's say the resident hit his head. She did not observe any marks or bruising to the resident's face or body. The Occurrence Report Protocol (undated) was provided by the Director of Nursing (DoN) on 7/26/13 at 12:58 p.m. The DoN indicated the protocol was current. The policy indicated, "The charge nurse will complete the incident report in the Risk Management Portal under the			

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	"Active" section. Complete all sections of the report -Details, Injuries, Factors, Witnesses, Action, signature. Details- this should contain the details (description of the incident). Injuries-this will contain any injuries related to the incident. Factors-this is for any factors that contributed to the incident. Witness-this will contain any witness statements that were obtained. Action-this will contain notification of physician and family, also the progress note will be completed from here (use the correct template e.g. (that is) fall or injury notes), as well as the triggered UDA [computer system assessment] (if applicable). Signature-Charge nurse will sign the report. The charge nurse will also complete the post-fall investigation from on paper and turn into the DON. The Charge nurse will review and update the care plan with the new intervention and document the new intentions in the Fall progress note template as well. Complete initial Non-pressure skin report if there is an injury. Complete neuro-checks under the assessment tab of the chart if the fall is unwitnessed or the resident hit head. Use the paper neurochecks from as a guide as to when the checks are to be completed, after completing the assessment in the			

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	system just initial that it is completed on the paper form. This will be kept with the Alert Charting Forms as a reminder of when they are due to be completed. The charge nurse will review the care plan and add new interventions. Add the resident to alert charting for the follow-up for 3 days." Interview with the Nurse Consultant and DON on 7/26/13 at 10:39 a.m., indicated there was no assessment or Physician notification done for Resident #E until 5/16/13 after he hit his head in the shower on 5/15/13. It was further indicated Nurse #5 should have assessed the resident and started neurochecks on 5/15/13. 3.1-45(a)(1) 3.1-45(a)(2)			

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F000502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.			
	Based on record review and interview, the facility failed to ensure a Urinalysis with a Culture & Sensitivity laboratory test was completed for 1 of 3 residents reviewed for past urinary tract infections in the sample of 14. (Resident #H) Findings include: The closed record for Resident #H was reviewed on 7/25/13 at 2:00 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, acute respiratory failure, malignant neoplasm of the colon, and anemia. Review of the 5/2013 Physician orders indicated there was an order written on 5/27/13, to obtain a urinalysis and urine culture and sensitivity laboratory test on 5/27/13. Review of the laboratory test results indicated there was no report of the results of the urinalysis and culture and sensitivity being completed in May 2013 or June 2013.	F000502	**F502 The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · Physician for Resident #H was notified of missed lab. Resident #H was discharged from facility. **2) How the facility identified other residents:** · Review of lab orders received in last 30 days to ensure completion as ordered, and physicians notified as needed. **3) Measures put into place/ System changes:** · Licensed staff will be educated regarding procedure for processing lab orders and tracking to ensure labs are completed as ordered. · Lab orders will be reviewed 5x/week to ensure labs are completed as ordered. · DON/designee is	08/23/2013

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	The 5/2013 Nursing Progress Notes were reviewed. An entry was made on 5/20/13 at 4:31 p.m. The entry indicated the resident was admitted to the facility from the hospital on 5/17/13. The entry also indicated the Nurse Practitioner was in to see the resident and an order was written to obtain a urine specimen on 5/27/13. The 5/2013 Medication Administration Record was reviewed. There were Physician orders for the Resident to receive Merrem (an antibiotic) 1 Gram every 8 hours Intravenously (through an IV (intravenous) for an infection for 4 days. The Merrem IV antibiotic was last signed out on 5/22/13 at 4:00 p.m. When interviewed on 7/26/13 at 10:50 a.m., the Nursing Unit Manager indicated the resident was admitted from the hospital and was being treated with an IV antibiotic for the infection upon admission to the facility. The Unit Manager indicated the urinalysis and culture test was ordered to be completed after the completion of the antibiotics. The Unit Manager indicated the laboratory test was never completed as ordered. This federal tag relates to Complaint		responsible for oversight of these audits. **4) How the corrective actions will be monitored:** · The results of these audits will be reviewed in Quality Assurance Meeting monthly x3, then quarterly x1 for a total of 6 months. **5) Date of compliance: 8/23/13**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	2350 TAFT ST GARY, IN 46404

(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
	IN00128277. 3.1-49(a)			