

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2012
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NAME OF PROVIDER OR SUPPLIER TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
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F0000	<p>This visit was for the Investigation of Complaints IN00105776 and IN00106517.</p> <p>Complaint IN00105776- Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00106517-Substantiated, Federal deficiencies related to the allegations are cited at F279 and F280.</p> <p>Survey dates: April 2 and 3, 2012</p> <p>Facility number: 000137 Provider number: 155232 AIM number: 100266140</p> <p>Survey team: Delinda Easterly, RN TC Ginger McNamee, RN Karen Lewis, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 47 Total: 51</p> <p>Census payor type: Medicare: 4 Medicaid: 47 Total: 51</p>	F0000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</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>Sample: 9</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 4, 2012 by Bev Faulkner, R.N.</p>				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to initiate a care plan problem for the use of Lovenox [an anticoagulant] medication for 1 of 6 residents reviewed for care plans in a sample of 9. [Resident #B]</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 4/2/12 at 3:30 p.m. The resident's diagnoses included, but were not limited to, glaucoma, diabetes mellitus type II, and history of pulmonary</p>	F0279	<p><u>F279 DEVELOP COMPREHENSIVE CARE PLANS</u></p> <p>1. RESIDENT B HAS BEEN DISCHARGED FROM THE FACILITY AND NO LONGER RESIDES AT TCHC.</p> <p>2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED . ALL CARE PLANS/CNA ASSIGNMENT SHEETS RELATED TO ANTICOGULANT USE HAVE BEEN REVIEWED FOR ACCURACY. (ATTACHMENT 1)</p>	04/16/2012	

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	<p>embolism.</p> <p>The resident had a 11/24/11, signed physician order for Lovenox 100 mg prefilled syringe give 0.9 ml [90 mg] subcutaneously two times a day for 3 months.</p> <p>Review of the care plan for Resident #B lacked any problems, goals, and/or interventions related to the use of Lovenox.</p> <p>Review of the Resident's Medication Administration Records for December, 2011, and January, 2012, indicated the resident had received the Lovenox injections two times a day as ordered.</p> <p>During an interview with the Director of Nursing on 4/3/12 at 9:30 a.m., she indicated the resident refused the Lovenox injections in the month of February.</p> <p>During an interview with the Director of Nursing on 4/3/12 at 10:57 a.m., she indicated the MDS [Minimum Data Set] nurse develops the care plans.</p> <p>During an interview with the MDS nurse on 4/3/12 at 11:20 a.m., she indicated she only develops care plans related to the MDS assessment triggers. She indicated</p>		<p>3. ALL NURSING STAFF HAVE BEEN RE-EDUCATED RELATED TO PROPER DOCUMENTATION OF CARE PLANS RELATED TO USE OF ANTICOAGULANT MEDICATIONS.</p> <p>4. D.O.N./DESINEE WILL UPDATE CARE PLANS/CNA ASSIGNMENT SHEETS WITH NEW ORDERS DAILY ON SCHEDULED DAYS OF WORK TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOMLY EVERY QUARTER TO ENSURE RESIDENTS RECEIVING ANTICOAGULANT MEDICATIONS ARE CARE PLANNED. (ATTACHMENT 2)</p> <p>5. RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS AN PLAN OF ACTION ADJUSTED ACCORDINGLY</p> <p>CORRECTION DATE: APRIL 16, 2012</p>		

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	<p>the Director of Nursing and the Assistant Director of Nursing develop care plans related to the resident's diagnoses and medications.</p> <p>This Federal tag relates to complaint IN00106517.</p> <p>3.1-35(a) 3.1-35(b)(2)</p>			

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to update a care plan to reflect a resident's wishes for 1 of 6 residents reviewed for updated care plans in a sample of 9. [Resident #B]</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 4/2/12 at 3:30 p.m. The resident's diagnoses included, but were not limited to, glaucoma, diabetes mellitus type II, and history of pulmonary embolism.</p> <p>Resident #B had a 12/7/11, care plan</p>	F0280	<p><u>F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</u></p> <p>1. RESIDENT B HAS BEEN DISCHARGED FROM THE FACILITY AND NO LONGER RESIDES AT TCHC. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. ALL RESIDENT ADL PREFERENCES PER SHAVING WILL BE REVIEWED AND UPDATED. (ATTACHMENT 3)</p> <p>3. ALL STAFF HAVE BEEN RE-EDUCATED RELATED ADL CARE PLAN PREFERENCES AND CNA ASSIGNMENT SHEETS.4. D.O.N./DESINEE WILL UPDATE ADL CARE PLANS/CNA ASSIGNMENT SHEETS DAILY ON</p>	04/16/2012			

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	<p>problem indicating the resident required extensive assistance in performing her Activities of Daily Living. An intervention for this problem was to shave facial hair as needed.</p> <p>Review of a 1/20/12, "Report of Concern" left on the conference room table on 4/3/12 at 8:00 a.m., indicated the resident was voicing concerns related to her facial hair being shaved while in the shower on 12/27/12. The report indicated the resident was a nurse and was concerned about the increased risk of bleeding with being shaved as a possible side effect of medication she was receiving . The resident refused to let the CNA shave her facial hair and voiced her concerns to the nurse on duty. The report indicated the Director of Nursing had been made aware of the incident on 12/27/11.</p> <p>During an interview with the Director of Nursing on 4/3/12 at 9:30 a.m., she indicated she was off work on 12/27/12 and was not made aware of the shaving incident until 1/20/12.</p> <p>During an interview with the Director of Nursing on 4/3/12 at 10:57 a.m., she indicated the MDS [Minimum Data Set] nurse develops and updates the care plans. She further indicated the care plan should have been updated related to the resident's</p>		<p>SCHEDULED WORK DAYS OF WORK TIMES 1 WEEK, 3 TIMES WEEKLY FOR 3 WEEKS, 2 TIMES WEEKLY FOR 2 MONTHS AND RANDOMLY EVERY QUARTER TO ASSURE PREFERENCES ARE MAINTAINED. (ATTACHMENT 2) 5. RESULTS OF THESE REVIEWS WILL BE DISCUSSED DURING THE FACILITY QUARTERLY QA MEETINGS AN PLAN OF ACTION ADJUSTED ACCORDINGLY. CORRECTION DATE: APRIL 16, 2012</p>				

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	<p>Activities of Daily Living needs.</p> <p>During an interview with the MDS nurse on 4/3/12 at 11:00 a.m., she indicated she only develops care plans related to the MDS assessment triggers. She indicated all other updates related to the care plans should be completed by the staff nurses.</p> <p>This Federal tag relates to Complaint IN00106517.</p> <p>3.1-35(b)(2)</p>			