

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
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NAME OF PROVIDER OR SUPPLIER  TERRACE AT TOWNE CENTRE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7252 ARTHUR BLVD MERRILLVILLE, IN 46410
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R 0000  Bldg. 00	<p>This visit for the State Licensure Survey.</p> <p>Survey Dates: July 29 &amp; 30, 2015</p> <p>Facility Number: 002392 Provider Number: 002392 AIMS Number: N/A</p> <p>Census Bed Type: Residential: 55 Total: 55</p> <p>Sample: 10</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p><b>Disclaimer: This plan of correction is submitted as required under either or both state and federal law. The submission of this plan of correction on August 17, 2015 does not constitute an admission of fault of liability to the government entity of any third party, on the part of The Terrace at Towne Centre, as to the accuracy of the surveyors' findings of the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the community's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in rule 47 of the federal rules of evidence and any corresponding state rules of civil procedure should be inadmissible in any proceeding on that basis and the community reserves the right to object to the admission of this statement of deficiency or the plan of correction under any other theory of law. The</b></p>	
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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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R 0090 Bldg. 00	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen</p>		<p><b>community submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action against the community or any employee, agent officer, director, attorney or shareholder of the community or affiliated companies</b></p>	

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	<p>(18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on observation, record review, and interview, the facility failed to maintain at least 2 years of annual surveys and subsequent surveys for 1 of 1 survey books reviewed</p> <p>Finding includes:</p> <p>On 7/30/15 at 12:10 p.m., the survey book was reviewed. At that time, the only survey in the book was the last annual State Licensure survey dated May 2014. The previous survey as well as two complaint surveys were not posted in the book. Complaint survey dated 10/1/14 and Complaint survey dated 5/7/15 were not in the survey book.</p>	R 0090	The corrective action that has been accomplished was survey book was immediately updated. Survey book currently reflects two years of annual surveys including complaint surveys 10-1-2014 and 4-17-2015. Upon reviewing updated survey book, no resident or employee were affected by this deficiency. The measures that were put into place and systemic changes the facility will make to ensure that deficient practice does not recur included a survey book audit form that was created to monitor compliance which was initiated 8-10-2015. Survey book will be audited weekly for 12 months by Director of Nursing and/or designee.	08/10/2015			

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R 0154 Bldg. 00	<p>Interview with the Director of Nursing on 7/30/15 at 1:00 p.m., indicated she was unaware the last two years of surveys including all subsequent complaint surveys needed to be posted in the book.</p> <p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure the kitchen was clean and in good repair related to malfunctioning dishwasher gauges, rusty fixtures, green, white, and discolored substances on piping and fixtures, cracked and peeling caulking, and missing face plates over electrical fixtures. (The Assisted Living Kitchen) Finding includes: During the initial sanitation tour of the kitchen on 7/29/15 at 8:55 a.m., with the Dietary Manager the following was observed: 1. The dishwasher gauge registered the wash cycle at 150 degrees Fahrenheit and the rinse cycle registered 130 degrees</p>	R 0154	The corrective actions that has been accomplished are as follows: On August 1, 2015 painting contractor completed a rust eliminator process. Metal piping will be wrapped with protective wrapping by August 28, 2015. The temperature gauge on dish machine was repaired on July 31, 2015. Zero residents were affected by deficiency due to dishes being transferred and sanitized in main kitchen. Face plate socket was replaced on July 31, 2015. Caulking will be removed and replaced with new caulk by August 28, 2015. The measures that will be put into place to ensure that deficient practice does not recur includes kitchen and maintenance audit to be performed by Dietary supervisor and/or designee 3 times a week for 6 months	08/28/2015

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	<p>Fahrenheit.</p> <ol style="list-style-type: none"> <li>2. The metal shelving over the beverage servery was rusty.</li> <li>3. The reach in Refrigerator #2 was rusty on the outside along the bottom.</li> <li>4. The dishwasher was rusty with a white substance along the front and along the sides of the lift door.</li> <li>5. There was a green substance on the metal piping underneath and behind the beverage servery.</li> <li>6. There was a green substance on the metal piping behind the ice machine.</li> <li>7. The white drain in front of the dishwasher had an accumulation of dirt and debris.</li> <li>8. There was a white substance along the floor tile behind the sink.</li> <li>9. There was a green substance on the metal pipes behind the sink.</li> <li>10. There was an accumulation of discolored substances on the parts on the top and underneath the bottom of the dishwasher.</li> <li>11. There was rust on the hood of the dishwasher.</li> <li>12. The main metal food servery was rusty.</li> <li>13. The wall next to the main metal</li> </ol>			

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	<p>servery was rusty and the paint was peeling,</p> <p>14. The caulking around the handwashing sink was peeling from the wall and the shut off valves underneath the sink were rusty.</p> <p>15. The electrical fixture next to the reach in Refrigerator #2 was missing a face plate.</p> <p>Interview at the time with the Dietary Manager indicate all the above was in need of cleaning and/or repair.</p> <p>Continued interview with the Dietary Manager on 7/30/15 at 11:30 a.m., indicated the dishwasher was not reaching the appropriate temperature correctly, the wash cycle should have registered at 140 degrees Fahrenheit and the rinse cycle should have registered 180 degrees Fahrenheit. She further indicated the temperature gauge was broken and needed to be replaced.</p> <p>Review of the current policy " Washing and Sanitizing Dishes/Utensils " provided by the Dietary Manager on 7/30/15 at 11:30 a.m., indicated, " ...the wash water temperature must be a minimum of 140 degrees Fahrenheit, and the rinse water must reach 180 degrees</p>			

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R 0217  Bldg. 00	<p>Fahrenheit.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure each resident's service plan evaluation was current and up to date to reflect the resident for 1 of 7 service plans reviewed in the sample of</p>			R 0217	The corrective action that has been accomplished for Resident #2 was that plan of care was updated on July 31, 2015 to reflect all current needs of the resident. Director of Nursing reviewed each resident's plan of		08/14/2015

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R 0241	<p>10. (Resident #2)</p> <p>Finding includes:</p> <p>The record for Resident #2 was reviewed on 7/29/15 at 11:00 a.m. The resident's diagnoses included, but were not limited to, stroke, left sided weakness, and infected skin tear.</p> <p>The skin assessment record indicated on 6/18/15 the resident developed a skin tear in which the facility was monitoring and treating.</p> <p>On 6/23/15 the resident was admitted to the hospital with an infected skin tear. The resident returned to the facility on 7/22/15 still with an infection. He was then sent back out to the hospital for more treatment and returned on 7/27/15.</p> <p>The resident's service plan had been updated on 4/24/15 and there was no documentation or information regarding the infected skin tear wound.</p> <p>Interview with the Director of Nursing on 7/29/15 at 2:45 p.m., indicated the resident's service plan was not updated to reflect the infected skin tear wound.</p>		<p>care on August 5, 2015 which totaled 47, to ensure that plans of care accurately and currently reflects residents care needs and how it will be provided. The measures that will be put into place to ensure that deficient practice does not recur includes an educational in-service that was completed on August 14, 2015 to educate nursing staff on the importance of updating all service plans to reflect residents current needs. Five service care plans will be audited weekly for 12 months by Clinical Nurse Liaison and/or designee and will be monitored by the implementation of a service plan tracking form. The date that systemic changes were completed was August 14, 2015.</p>				
	410 IAC 16.2-5-4(e)(1)						

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Bldg. 00	<p><b>Health Services - Offense</b></p> <p>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review and interview, the facility failed to ensure medications were given as ordered for 1 of 5 residents observed for medication administration. (Resident #9)</p> <p>Finding includes:</p> <p>On 7/30/15 at 8:30 a.m., QMA #1 was observed preparing medications for Resident #9. The resident received Senna (a laxative) 50/8.6 milligrams (mg) two tablets, and Acetaminophen 500 mg, one tablet. As the QMA was dispensing the medications, a 10 milliequivalents (meq) Potassium Chloride tablet fell on the floor. The QMA indicated at this time, she "didn't have an extra tablet and the resident receives another dose at 12:00 p.m. and 5:00 p.m."</p> <p>The record for Resident #9 was reviewed on 7/30/15 at 9:30 a.m. Physician's Orders dated 10/19/14, indicated the resident was to receive Acetaminophen 500 mg three times a day at 6:00 a.m., 12:00 p.m., and 4:00 p.m. The resident</p>	R 0241	<p>The corrective action that has been accomplished for QMA #1 is as follows: (A) QMA was immediately educated on proper protocol - when medication needs to be destroyed and/or replaced (B) QMA #1 received an individual counseling on July 31, 2015 to educate on residents 7 rights of medication administration. The facility determined that all residents could be affected by this deficient practice. On August 1, 2015 an in-service was provided to all nurses and qualified medication assistants to educate on proper medication administration. The measures that will be put into place consists of a medication administration observation skills audit was completed on August 14, 2015 for nurses and qualified medication assistants and will be done monthly and as needed. Medication administration observation skills check will be done monthly by Director of Nursing, Clinical Nurse Liaison and/or by designated nursing staff. The date that systemic changes will be completed by is August 14, 2015. The corrective</p>	08/20/2015

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R 0349  Bldg. 00	<p>was to receive Potassium Chloride Micro Extended Release tablets, 1 tablet three times a day at 6:00 a.m., 12:00 p.m., and 4:00 p.m.</p> <p>Interview with the Director of Nursing (DON) on 7/30/15 at 1:00 p.m., indicated the resident should not have received the Acetaminophen at 8:30 a.m. if it was scheduled for 6:00 a.m. The DON also indicated the QMA had indicated that she had not given the Potassium Chloride.</p> <p>The July 2015 Medication Administration Record (MAR), indicated the Acetaminophen and the Potassium Chloride had been initialed as being given at 6:00 a.m.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible.</p>		<p>action that has been accomplished for Resident #9 was resident was placed on 72 hour charting on July30, 2015 to monitor for any adverse reaction related to medication error. Physician and family immediately notified. The facility reviewed each resident's record and determined that all residents could be affected by the deficient practice. On August 14, 2015 all nurses and qualified medication assistants were in serviced to educate on proper medication administration. On August 14,2015 all nurses and qualified medication assistants signed an acknowledgement letter indicating understanding of proper medication administration and also attended in servicing on August 14, 2015 to educate on proper medication administration. The facility's quality assurance program that was put into place was the initiation of a monthly medication observation skills check.Systemic changes will occur by August 20, 2015.</p>				

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	<p>(4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to documentation of a heart rate for a resident receiving a heart medication for 1 of 7 records reviewed. (Resident #7)</p> <p>Finding includes:</p> <p>The record for Resident #7 was reviewed on 7/29/15 at 12:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and chest pain.</p> <p>A Physician's Order dated 7/19/14, and listed on the July 2015 Physician's Order Summary (POS), indicated the resident was to receive Metoprolol (a medication used to treat high blood pressure and control heart rate) 25 milligrams (mg) twice a day at 10:00 a.m. and 9:00 p.m. The medication was to be held if the resident's systolic blood pressure (top number) was less than 100 or heart rate below 60 beats per minute.</p> <p>A Physician's Order dated 7/18/14, and listed on the July 2015 POS, indicated the resident's blood pressure and heart rate were to be checked twice a day at 10:00 a.m. and 5:00 p.m.</p>	R 0349	<p>The corrective actions that has been accomplished for Resident #7; on July 31, 2015 a physicians' order was received to change time that blood pressure and heart rate is to be taken to coincide with blood pressure medication administration time. The facility reviewed each resident's record and determined that all residents who has orders for blood pressures and pulse to be taken are at risk. A communication was made to all nurses and qualified medication assistants to follow physician's orders when directed totake B/P and pulse when administering hypertension medications. An in-service was held August 14, 2015 on assessment and documentation. Proper documentation will be audited three times per week by Clinical Nurse Liaison and/or designee and will be ongoing for 6 months.</p>	08/14/2015			

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R 0414 Bldg. 00	<p>The April 2015 Medication Administration Record (MAR), indicated the resident's heart rate was not documented at 5:00 p.m. 4/2-4/29/15.</p> <p>The May 2015 MAR, indicated the resident's heart rate was not documented at 5:00 p.m. for the entire month of May.</p> <p>Interview with the Director of Nursing (DON) on 7/30/15 at 11:00 a.m., indicated the resident's heart rate should have been documented at 5:00 p.m. for the months of April and May 2015. The DON also indicated a clarification order needed to be obtained to see if the resident's blood pressure and heart rate should be monitored at 9:00 p.m. when the Metoprolol was given rather than 5:00 p.m.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review and interview, the facility failed to ensure handwashing was completed after direct resident contact and as well as after picking up a medication off of the floor for 1 of 1 resident treatments observed and during Medication administration.</p>	R 0414	The corrective action(s) that has been accomplished for QMA #1 and RN#1 was an individual educational counseling was done reviewing the facility's policy regarding hand hygiene on July 31, 2015. An all staff in-service was held on August 7, 2015 to educate staff on universal	08/20/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(Resident #2)</p> <p>Findings include:</p> <p>1. On 7/30/15 at 8:30 a.m., QMA #1 was observed to drop a pill on the floor. The QMA proceeded to pick up the pill and place it in a medication cup on top of the medication cart. The QMA then proceeded to prepare medications for the resident. The QMA did not wash her hands nor use an alcohol hand gel after picking the pill up off the floor.</p> <p>Interview with the Director of Nursing on 7/30/15 at 10:55 a.m., indicated the QMA should have washed her hands after picking up the pill from the floor.</p> <p>2. On 7/30/15 at 10:12 a.m., RN #1 was observed performing a treatment for Resident #2. At that time, RN #1 donned a pair of clean gloves to both hands, she did not wash her hands with soap and water or use alcohol gel prior to placing the gloves on her hands. She then prepared a wash basin of warm water and soap to clean the wound. The resident was observed laying in bed on his right side. The RN removed the resident's pants to his mid thigh area and pulled back the resident's brief. The RN was looking for the skin tear to perform the treatment, she looked inside the resident's brief and bowel movement was observed.</p>		<p>precautions, infection control and hand hygiene per company's policy. The facility recognizes that all residents have the potential to be affected by deficiency. Subsequently to prevent deficiency from recurring all employees were required to demonstrate proper hand washing technique. Audits will be conducted monthly for six months to ensure deficient practice does not recur. The corrective action will be monitored by the Director of Nursing or designee. The date systemic changes will be completed by is August 20, 2015.</p>				

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	<p>After unsuccessful in finding the skin tear, she pulled out her cell phone from her pocket (with the same gloved hands) and starting scrolling on the screen with her fingers. The RN indicated she was looking for her flashlight feature on the phone so she could see the resident's skin better. After finding the light she then scanned her cell phone over the resident's left thigh and buttock area and determined she needed to clean the resident's bowel movement first. She placed the cell phone back into her pocket. The RN walked into the bathroom, with the same gloved hands and picked up a clean washcloth to wipe the resident's buttock area and clean the bowel movement. She then proceeded to clean the resident's bowel movement. After providing incontinence care, with the same gloved hands, she reached into her pocket again and pulled out her cell phone to obtain the flashlight feature. She used her cell phone to observe the resident's thigh and buttock area again. After not being able to find the area, she removed her gloves and threw them away. She picked up the Treatment Administration Record (TAR) with her bare hands and then placed it back down. At that time, she washed her hands with soap and water and donned another pair of clean gloves. The RN had the resident move to his backside and proceeded to</p>			

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	<p>remove his pants down further so she could observe his front side. She then asked the resident to move onto his left side so she could try to find the skin tear. After the resident had rolled over to his left side, the RN reached into her pocket again with her gloved hands and pulled out her cell phone to use the flashlight feature. The RN determined at that time, the skin tear must be healed and proceeded to change the resident's soiled pull up and pulled the resident's pants back up.</p> <p>Interview with RN #1 at 10:27 a.m., indicated she should have washed her hands before donning the clean gloves and changed her gloves and washed her hands before grabbing her cell phone.</p> <p>The current 3/1/04 Hand Hygiene Policy provided by the Director of Nursing on 7/30/15 at 10:55 a.m., indicated "Hands should be washed after gloves are removed when there has been contact with blood, body fluids.... When administering orals with no mechanical assistance given to the resident, a suitable spray or antiseptic lotion is used before and after medication administration."</p>			