

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/22/2012	
NAME OF PROVIDER OR SUPPLIER HAMILTON HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD FORT WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
R0000	<p>This visit was for the Investigation of Complaint IN00103082.</p> <p>Complaint IN00103082 - Substantiated. State residential deficiency related to the allegations cited at R349.</p> <p>Survey dates: 2/21-22/12</p> <p>Facility number: 004686 Provider number: 004686 AIM number: N/A</p> <p>Survey team: Ellen Ruppel, RN</p> <p>Census bed type: Residential: 33 Total: 33</p> <p>Census payor type: Other: 33 Total: 33</p> <p>Sample: 3</p> <p>This state finding is cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/23/12 by Suzanne Williams, RN</p>	R0000					

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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R0349	<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. (4) Systematically organized.</p> <p>Based on record review and interviews, the facility failed to maintain complete and accurately documented records related to the changing of dressings on a pressure area for 1 resident in a sample of 3, who had dressing changes ordered. Resident B</p> <p>Findings include:</p> <p>The closed clinical record of Resident B was reviewed, on 2/21/12 at 11:00 a.m., and indicated the resident had been admitted to the facility 7/9/11. Her diagnoses included, but were not limited to: Alzheimer's disease, osteoporosis and hypothyroidism.</p> <p>Hospice notes, dated 11/23/11, indicated the resident had begun care from hospice and the admission skin sheet indicated she had a stage III pressure area on the right hip.</p>	R0349	The submission of this plan response and the plan of correction included in i not a legal admission that a defecency exist or that thi statement of deficiencies exist or that this statement of defeciencie was correctly cited. This is also not to be conctructed as an admiion against interest by facility or any employee agents and other individuals who draft or may be discussed in this response and plan of correction.In additdion preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctnes of any concluions set fourth in this allegation by the survey agency.resident B passed away on hopice care.Resident B was not receiving wound care services by residence staff. The care was provided by the home hospice agency staff. Residence staff were documenting when hospice staff was treating	03/09/2012			

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	<p>Treatment sheets, from November and December of 2011 and from January 2012, indicated the hip wound was being treated with xenaderm, then on 12/15/11 the treatment was changed to Santyl with telfa covering and on 12/27/11, the treatment was changed to wound spray and alginate with gauze covering. The treatments were ordered on a daily basis or as needed when the dressings were soiled.</p> <p>Resident Services Notes, dated 12/27/11 at 11:00 a.m., indicated the area was 2 cm by 3 cm with black eschar removed, revealing a depth of 2.5 cm with some tunneling present. The note had been written by RN #1, who no longer was employed by the facility.</p> <p>Review of the signatures on the treatment sheets indicated 26 of 67 entries, from 11/23/11 to 1/31/12, indicating the dressing change had been done were initialed by Qualified Medication Aides (QMAs).</p> <p>During an interview with QMA #2, on 2/21/12 at 12:45 p.m., she indicated she had initialed some of the entries on the treatment record, but had not done the treatments.</p> <p>During an interview with QMA #3, on</p>		<p>residents. Current staff were re-educated as to company policy and state regulations to document only the care that they are personally providing. The Regional Director of Quality and Clinical Management will review random clinical records for the next 3 months, then quarterly thereafter to ensure proper documentation of care is provided.</p>				

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	<p>2/22/12 at 9:15 a.m., she indicated she had also initialed the treatment record, but had not done the treatments. She indicated she initialed the record when the licensed nurse from hospice or the licensed facility nurse had done the treatments.</p> <p>This state deficiency relates to Complaint IN00103082.</p>						