

NURSING HOME REPORT

KINGSTON CARE CENTER



Address: 1010 W. Washington Center Road
Phone: 489-2552
Owner: Kingston Care Center of Fort Wayne LLC
Officers: M. Rumman, Frederic Wolfe, Kent Libbe and Larry Nirschl
Most recent change in ownership: None
Most recent name change: Jan. 6, 2006
Status: For profit
Sprinkler system: Full
Resident rooms with battery smoke alarms: 40 of 53
Resident rooms with system-based smoke alarms: 13 of 53
Fire safety deficiencies: 0
Average fire deficiencies in Indiana facilities: 2
Administrator: Molly Linder
Hire date: June 27, 2007

Beds: 120
Census: 101 people as of Dec. 4
Most recent annual survey:
Date: Dec. 4
In substantial compliance? No
When compliance met: Jan. 23
Deficiencies found in Levels D-L: 5D, 1E, 1F
Level D:
 ◆ Failure to ensure the dignity of a resident was maintained by serving her supper in a timely manner as her tablemates were served. Her tablemates were served between 4:40 p.m. and 5:20 p.m.; surveyors noted the fourth resident was sitting at the table with no food. By the time a dining room staff member noticed the woman had not been given her food, two of the tablemates were ready to leave. The woman said it was the second time in one week that staff forgot to serve her.
 ◆ Failure to revise a resident's care plan to include implementation of precautions after the resident fell four times between July and September. The therapy department had recommended an alarm for his wheelchair that would alert staff if he was not sitting properly on his seat cushion. No alarm, however, was ever used.
 ◆ Failure to follow a resident's care

plan by ensuring a lab test (urinalysis) was done according to doctor's orders.
 ◆ Failure to ensure fall prevention interventions were developed and implemented for the above-mentioned resident at high risk of falls.
 ◆ Failure to ensure lab work was done on the above-mentioned resident.
E Level:
 ◆ Failure to ensure residents had nutritious evening snacks when the time span between supper and breakfast the following day exceeded 14 hours. Supper was served as early as 4:20 p.m. with breakfast at 7:05 a.m. the next day.
Level F:
 ◆ Failure to ensure food transported through the hallway from the kitchen to a kitchenette was not contaminated and failure to sanitize tables properly after meals; failure to keep cold food at the correct temperature; parchment paper covering foods on a rolling cart blew off, exposing the food to possible contamination. In the dining room, drinking glasses were placed upside on the tables between meals, with the rims touching the bare tables. Surveyors tested the disinfectant

solution used to wash the tables and it contained zero parts per million of disinfectant; minimum is to be 200 ppm of disinfectant in the solution.
Substantiated complaints in 2007: 6
Previous year: None
Complaint findings in 2007: 7D, 4E
 ◆ Failure to ensure call lights were answered in a timely manner for seven of 17 residents. Both family members and residents told staff call lights sometimes were not answered for 20 to 30 minutes.
 ◆ Failure to ensure oxygen did not run out for one resident. The resident told surveyors the situation had happened more than once and when it did, "I get a pounding in my chest," she said.
 ◆ Failure to ensure two residents who used wheelchairs were able to comfortably reach their bathroom sinks. A third resident could not get into either his room or bathroom in his wheelchair without banging into his roommate's bed.
 ◆ Failure to monitor the intakes and outputs of one resident and failure to follow doctor's orders to not give a resident blood pressure-lowering medicine if blood pressure fell below a certain level.
 ◆ Failure to follow care plans for two residents; failure to keep accurate

records on a resident whose pressure sore worsened and to let the family know of the worsening condition.
 ◆ Failure to ensure the dignity of 14 residents by answering their call light in a timely manner when they needed assistance to use the bathroom.
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff:
Kingston Care Center: 1 hour, 30 minutes
Statewide average: 1 hour, 24 minutes
National average: 1 hour, 18 minutes
For nursing assistants:
Kingston Care Center: 2 hours, 2 minutes
State average: 2 hours
National average: 2 hours, 18 minutes
National Nursing Home Compare Score (based on three years of data): (The lower the score, the better.)
Kingston Care Center: 113
Statewide average: 193
State licensure actions this quarter: None
Federal actions imposed: None

LUTHERAN HOME



Address: 6701 S. Anthony Blvd.
Phone: 447-1591
Owner: Lutheran Homes Inc., Fort Wayne
Officers: Lawrence Moeller, John Peterson, Robert Meyer and Eric Bierberich
Most recent change in ownership: None
Status: Nonprofit
Sprinkler system: Partial
Fire safety deficiencies: 7
Average deficiencies in Indiana facilities: 2
Resident rooms with battery smoke detectors: 5 of 183
Resident rooms with system-based smoke detectors: 25 of 183
Administrator: Matthew Maupin
Hire date: March 23
Beds: 262 licensed as nursing home; 115 licensed as residential
Census: 158 in nursing home as of Dec. 27
Most recent annual survey:
Date: Dec. 14
In substantial compliance? No
When compliance met: Feb. 6
Deficiencies found in Levels D-L:

12D, 3E
Level D:
 ◆ Failure to notify a resident's doctor regarding abnormal urine characteristics.
 ◆ Failure to ensure physical restraints were medically necessary for one resident and failure to attempt reduction in restraint usage for two others.
 ◆ Failure to provide activities for one resident with depression. The resident was to have stimulating activities such as the radio or TV on in the room or to have one-on-one activities with staff, but surveyors noted for seven hours one day and for four hours on two other days none of the aforementioned activities were made available to the resident.
 ◆ Failure to ensure one resident was assessed for restraints that were being used; and failure to ensure a resident with an eye infection was treated with eye drops according to doctor's orders; for a third resident, staff failed to assess a resident's bowel incontinence; in another situation, a doctor ordered a urinary catheter be removed in a resident, yet staff failed to do an assessment on the resident's bladder function following removal.
 ◆ Failure to update the care plans for three residents. In one case, a resident was to be turned every two hours but surveyors noted staff did not do so. Another resident with high blood pressure was to have daily checks of her blood pressure, yet records showed that 15 days in November, no check was done. Staff

also failed to raise and cushion one resident's feet when the resident was in a wheelchair, in order to prevent pressure sores.
 ◆ Failure to ensure one resident was walked daily and that she did range-of-motion exercises, according to her care plan.
 ◆ Failure to ensure proper measures were taken to prevent development of or worsening of pressure sores on her tailbone.
 ◆ Failure to ensure an accident or worsening health did not occur due to lack of supervision. Surveyors noted one resident who was at risk for aspirating food and who was to be sitting upright when eating, was lying nearly prone in bed while feeding herself.
 ◆ Failure to ensure one resident's psychotropic drugs were adequately monitored.
 ◆ Failure to ensure a doctor provided necessary interventions for a resident whose blood sugar exceeded 200 more than 70 times from Oct. 1-31; 70 to 100 is normal range.
 ◆ Failure to obtain a blood lipids test every three months for a resident according to doctor's orders.
 ◆ Failure to ensure documentation was complete and accurate for three residents regarding incontinence, falls or mood and behaviors. One resident fell nine times between Sept. 27 and Dec. 4, according to one part of the clinical record, yet there was a doctor's note and other notes in the chart that showed the resident fell

another time in late October. In another case, the quarterly assessment said the resident gets out of bed on the day shift yet surveyors saw the resident in bed from 9:30 a.m. to 4:30 p.m. one day and from 9 a.m. to 1 p.m. another day. One nursing assistant told surveyors the resident had not been out of bed on Dec. 12 yet the assessment coordinator (called the minimum data set coordinator) said the nursing assistant had charted that the resident had been out of bed that day.
Level E:
 ◆ Failure to maintain the dignity of residents by knocking and asking permission to enter their rooms.
 ◆ Failure to develop care plans for a resident with bladder incontinence; failure to develop plans for assistance to a resident with bowel and bladder incontinence who could not remove clothing before toileting; failure to assess a resident who was to walk daily with two staff members' assistance, yet on two days surveyors never saw staff assist the woman to walk; failure to have care plans for activities and to prevent falls. Surveyors noted the chart of the aforementioned woman required she be walked daily, yet it was not done for 21 of 42 days.
 ◆ Failure to offer nutritious snacks when there was a more than 14-hour time span between supper and breakfast the following day. Five of six residents questioned said they were not offered evening snacks, but surveyors noted more than 15 hours

occurred between meals in one 24-hour period.
Substantiated complaints in 2007: 4
Previous year: 4
Complaint findings in 2007:
 ◆ Three complaints were substantiated but not serious enough to rate deficiencies.
 ◆ One complaint rated two level G deficiencies for quality of care issues; a female resident at high risk for falls was to have two people transfer her from bed to chair, but a nursing assistant attempted to assist with the transfer on her own; the resident sustained a cut to her head and required treatment at a hospital.
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff:
Lutheran Home: 1 hour, 13 minutes
Statewide average: 1 hour, 24 minutes
National average: 1 hour, 18 minutes
For nursing assistants:
Lutheran Home: 3 hours, 10 minutes
State average: 2 hours
National average: 2 hours, 18 minutes
National Nursing Home Compare Score (based on three years of data): (The lower the score, the better.)
Lutheran Home: 244
Statewide average: 193
State licensure actions this quarter: None
Federal actions imposed: Denial of new admissions Jan. 26-Feb. 2

PARKVIEW HOSPITAL CONTINUING CARE CENTER



Address: 2200 Randallia Drive
Phone: 373-6520
Owner: Parkview Health Inc., Fort Wayne

Officers: Mike Packnett, Sue Ehinger and Mark Nafziger
Most recent change in ownership: None
Most recent name change: None
Status: Nonprofit
Sprinkler system: Partial
Resident rooms with battery smoke alarms: 0 of 28
Resident rooms with system-based smoke alarms: 28 of 28
Fire safety deficiencies: 0
Average fire deficiencies in Indiana facilities: 2
Administrator: Kelly Borrer
Hire date: Feb. 19, 2001

Beds: 28
Census: 28 people as of Nov. 7
Most recent annual survey:
Date: Nov. 7
In substantial compliance? No
When compliance met: Dec. 11
Deficiencies found in Levels D-L:** 3D
D Level:
 ◆ Failure to do a comprehensive assessment of a resident by listening to the heart rate/breath sounds before, during and after administering a respiratory medication.
 ◆ Failure to follow doctor's orders for walking a resident in the hallway

twice a day after the resident had back surgery.
 ◆ Failure to meet the special needs of the above-mentioned resident who was to be assessed before, during and after being given an inhaled respiratory medication.
Substantiated complaints in 2007: 0
Previous year: 0
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff (for hospital-based, Medicare-only facilities):
Parkview CCC: 4 hours, 27 minutes
Statewide average for CCCs: 4 hours
National average: 2 hours, 42

minutes
For nursing assistants:
Parkview CCC: 2 hours, 12 minutes
State average: 2 hours, 36 minutes
National average: 2 hours, 36 minutes
National Nursing Home Compare Score (based on three years of data): (The lower the score, the better.)
Parkview CCC: 48
Statewide average: 193
State licensure actions this quarter: None
Federal actions imposed: None

THE CEDARS



Address: 14409 Sunrise Court, Leo
Phone: 627-2191
Owner: Cedar Creek Retirement Home Inc., Indianapolis
Officers: John Klopfenstein and David Bertsch
Most recent change in ownership: None
Most recent name change: none
Status: Nonprofit
Sprinkler system: Full
Fire safety deficiencies: None
Average deficiencies in Indiana facilities: 2
Resident rooms with smoke alarms: 0
Resident rooms with system-based alarms: 27 of 27
Administrator: Larry Watkins

Hire date: Sept. 13, 1993
Beds: 50
Census: 45 people as of Nov. 2
Most recent annual survey:
Date: Nov. 2
In substantial compliance? No
When compliance met: Feb. 7
Deficiencies found in Levels D-L: 7D, 1G
Level D:
 ◆ Failure to ensure least restrictive restraints were necessary for two residents who had full bedside rails. One resident had no doctor's order for side rails and one resident's doctor had ordered half rails.
 ◆ Failure to report and fully investigate an incident in which a staff member was reported by another staff member to have slammed down on the floor the doll of a resident with dementia; the aide who reported the incident also said she saw the same male staff member put a hand over the resident's mouth in an attempt to quiet her. No report to the state was made about the alleged incident, even though the facility has a zero-tolerance policy regarding all abuse, including emotional.

◆ Failure to ensure proper treatment of residents by a staff member – this was in reference to the above-mentioned incident involving a staff member throwing down a resident's doll. The social services director said the doll gave the woman comfort.
 ◆ Failure to follow the care plans for one resident who was to be taken to the bathroom before and after meals, at bedtime and as needed; and failure to provide toileting for another resident who required full care. The latter was observed from 8:45 a.m. to 1:28 p.m. without ever being toileted.
 ◆ Failure to use a special type of sleeve and leggings for a resident whose care plan called for the pressure-reducing aids, as ordered by a doctor. The resident, who was at high risk for skin breakdown, had a pressure sore on her left heel and current or healed tears on both elbows, yet surveyors noted she was in a chair from 8:45 to 11 a.m. without the protective coverings.
 ◆ Failure to provide for the toileting needs of two residents according to their care plans.

◆ Failure to document the required care for a resident with episodes of low blood sugar. Orange juice was to be given if the blood sugar dropped. Although the sugar dropped five times from July to October, record showed no juice was given.
Level G:
 ◆ Failure to ensure a resident was free of mental abuse. This deficiency is related to the above-mentioned resident who had a close attachment to a doll that was reported purposely slammed to the floor by a male staff member.
Substantiated complaints in 2007: 3
Previous year: 0
Complaint findings in 2007:
 ◆ Level D and G deficiencies for failure to fully investigate and report an incident or emotional abuse of a resident with dementia and failure to ensure residents free from any form of abuse.
 ◆ One level D for failure of a staff member to take a resident to the bathroom when she requested help.
 ◆ A level D was given for failure to ensure the dignity of a resident by covering her catheter bag from view

of the public or other residents.
 ◆ In post-survey reviews to the complaint survey, additional level D deficiencies were found.
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff:
The Cedars: 1 hour, 21 minutes
Statewide average: 1 hour, 24 minutes
National average: 1 hour, 18 minutes
For nursing assistants:
The Cedars: 2 hours, 13 minutes
State average: 2 hours, 24 minutes
National average: 2 hours, 18 minutes
National Nursing Home Compare Score (based on three years of data): (The lower the score, the better.)
The Cedars: 135
Statewide average: 193
State licensure actions this quarter: None
Federal actions imposed: Denial of payment for new admissions Feb. 2-7; federal civil money penalty of \$100/day March 3-13.