

NURSING HOME REPORTS

SAINT ANNE HOME



Address: 1900 Randallia Drive
Phone: 484-5555
Owner: Saint Anne Home of the Diocese of Fort Wayne-South Bend Inc.
Officers: J. William Lester, Mark Schenke, George Manning, John Eichman, James Fitzpatrick and Gary Windmiller
Most recent change in ownership: Catholic Charities of Diocese of Fort Wayne-South Bend, Oct. 1, 1997
Status: Nonprofit
Administrator: Mary Haverstick
Hire date: Aug. 4, 1986
Sprinkler system: full

Resident rooms with smoke alarms: 0 out of 103
Facility fire safety violations in past year: 5
Average fire violations in Indiana: 4
Beds: 166 Medicare and/or Medicaid beds included in survey
Census: 165 as of June 20
Most recent annual survey: June 20
In substantial compliance? No
When compliance met: Sept. 18
Deficiencies found in Levels D-L:** 5D; 1E
D Level:
 ◆ Physical restraints – failure to identify the medical symptoms necessitating the need for two residents to use recliner chairs with footrests up for extended periods of time. One of the residents was observed sitting in the reclining chair with her feet up from 2:15 to 5:18 p.m. one day. The resident was trying to get out of the chair. The resident had fallen out of the chair in May. For the other resident observed in a recliner, nursing staff said the recliner was used because

the woman, who had Alzheimer's, would get tired wheeling herself in her wheelchair. Yet surveyors said no doctor's orders existed for using the recliner as a restraint. This deficiency also cited for using bed rails for a resident who was comatose or semi-comatose and physically unable to use the rails. The director of nursing said bed rails were used with some residents because the beds came with the side rails.
 ◆ Comprehensive assessments – failure to complete an assessment to ensure safe feeding strategies were used with a resident who had swallowing difficulties. The resident was observed being fed while reclining in her wheelchair at about a 55-degree angle at one meal and an 80-degree angle during another meal. The resident was observed coughing after taking bites of food. A speech therapist had recorded that one resident needed verbal cueing to swallow properly, yet a nurse said she was not aware the resident required the cueing for

swallowing.
 ◆ Resident assessments – failure to ensure the aforementioned resident who was comatose and had full bed side rails had medical need for them.
 ◆ Accidents and supervision – failure to ensure one resident was sitting at a safe angle for eating.
E Level:
 ◆ Sanitary conditions of food preparation/service – failure to ensure opened packages of food were sealed tightly, failure to cover sliced pie stored in a cooler, failure to ensure hot food was kept at proper temperatures in one dining room and failure of staff to properly wash their hands during meal service.
Substantiated complaints in 2008: none
Previous year: none
Substandard quality of care designations in 2008: none
Immediate jeopardy designations in 2008: none
Federal Quality Initiative scores:
Staffing hours per resident per day

for licensed nursing staff:
 Saint Anne: 55 minutes
 State average: 1 hour, 24 minutes
 National average: 1 hour, 18 minutes
For nursing assistants:
 Saint Anne: 2 hours, 26 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)
 Saint Anne: 79
 Statewide average: 193
Overall federal Star Quality Rating*:** 3 out of 5 stars
State licensure actions in 2008: none
Federal actions imposed: none

TOWNE HOUSE RETIREMENT COMMUNITY



Address: 2209 St. Joe Center Road
Phone: 483-3116

Owner: Baptist Homes of Indiana Inc., Zionsville
Officers: Richard Keenan, James McDaniel, Roger Miller, Margaret McFrye and Marjorie Pauszek
Most recent change in ownership: none
Status: nonprofit
Administrator: B. Daniel Carr
Hire date: Nov. 17, 1985
Sprinkler system: full
Resident rooms with smoke alarms: 0 of 58
Facility fire safety violations in past year: 11

Average fire violations in Indiana: 4
Beds: 12 Medicare; no Medicaid; rest are private pay (only Medicare/Medicaid beds fall under CMS rules)
Census: 5 Medicare as of Sept. 15
Most recent annual survey: Sept. 15
In substantial compliance? Yes
Deficiencies found in Levels D-L:** none
Substantiated complaints in 2008: none
Previous year: 1
Substandard quality of care

designations in 2008: none
Immediate jeopardy designations in 2008: none
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff:
Towne House: 1 hour, 53 minutes
State average: 1 hour, 42 minutes
National average: 1 hour, 36 minutes
For nursing assistants:
Towne House: 1 hour, 59 minutes
State average: 2 hours, 30 minutes
National average: 2 hours, 42 minutes

National Nursing Home Compare Score (based on three years of data):
 (the lower the score, the better)
 Towne House: 63
 Statewide average: 193
Overall federal Star Quality Rating*:** 4 out of 5 stars
State licensure actions in 2008: none
Federal actions imposed: none

UNIVERSITY PARK HEALTH & REHABILITATION CENTER



Address: 1400 Medical Park Drive
Phone: 484-1558
Owner: Covenant Care Indiana Inc.
Officers: Robert Levin, Christine Sims, Marty Evans and Andrew Torok
Most recent change in ownership: NCS Inc., June 1, 1998
Status: For profit
Administrator: Liane Minier
Hire date: July 9, 2007
Sprinkler system: full
Resident rooms with smoke alarms: not available
Facility fire safety violations in past year: 7
Average fire violations in Indiana: 4
Beds: 96
Census: 80 as of May 28, 2008
Most recent annual survey: May 2

In substantial compliance? No
When compliance met: July 10
Deficiencies found in Levels D-L:** 8D, 1E
D Level:
 ◆ Comprehensive assessments – failure to complete quarterly assessments for one resident's need for bed side rails; records showed resident was totally immobile in bed and did not need rails, yet surveyors noted the rails were up.
 ◆ Resident assessments – failure to ensure one resident was accurately assessed for incontinence of bowel and bladder – one entry in the chart stated the resident was incontinent of bowel and bladder but another entry said resident was incontinent of bladder only; and failure to ensure a resident was assessed for risk of falls – one notation in chart said resident had no falls in past 180 days, yet record showed in another entry that the resident had fallen less than a month earlier.
 ◆ Comprehensive care plans – failure to update the care plan for one resident with weight loss – resident's doctor ordered a generous bowl of rice with resident's lunch and supper as well as extra desserts but care plan did not include the doctor's orders.

◆ Comprehensive care plans – failure to follow doctor's orders for a resident at risk of pressure sores. The resident was to have his legs elevated with pillows and his heels not touching the mattress or pillow, but surveyors observed his heels resting directly on the pillow. The administrator said the facility did not have a specific policy on following doctors' orders.
 ◆ Pressure sores – failure to "float" the above-mentioned resident's heels to prevent pressure sores.
 ◆ Accidents and supervision – failure to ensure the gaps between sections of bed side rails on one resident's bed were at a safe distance to prevent the resident's head, limbs or body from entrapment.
 ◆ Infection control – Failure to properly pass and transport snack foods through hallways to ensure the food was not contaminated; failure to keep the ice scoop handled by servers out of the ice chest; and failure to protect one resident's feeding tube from contamination while a nurse gave the resident medication through the tube. The nurse laid the end of the tube directly on the bed linens.
 ◆ Clinical records – failure to

complete the food and liquid intake records of three residents. No documentation was made during 19 nursing shifts of the doctor-ordered flushing of a resident's feeding tube; one resident had no documentation for food intake for 26 meals and another resident had none for seven meals. The administrator said the facility had no specific policies on documentation.
E Level:
 ◆ Pharmacy services – failure to ensure refill medications were ordered in a timely manner to ensure seven residents did not run out of their medications or miss scheduled doses. One resident, who did not get antibiotic doses as ordered by the doctor, told surveyors that the facility sometimes ran out of his meds. The resident had 11 doses of five different medications missed between March 1 and March 18, 2008. The other six residents missed in total 18 doses of their medications.
Note: Additional finding rating no deficiencies: four nursing assistants did not have TB tests fully completed and the administration said the facility had no policy for checking if

new hires' TB tests were completed.
Substantiated complaints in 2008: 2
Previous year: none
Substandard quality of care designations in 2008: none
Immediate jeopardy designations in 2008: none
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff:
 University Park: 1 hour, 32 minutes
 National average: 1 hour, 18 minutes
 State average: 1 hour, 24 minutes
For nursing assistants:
 University Park: 1 hour, 50 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)
 University Park: 183
 Statewide average: 193
Overall federal Star Quality Rating*:** 3 out of 5 stars
State licensure actions in 2008: none
Federal actions imposed: none

WATERS OF SUMMIT CITY



Address: 2940 N. Clinton St.
Phone: 484-0602
Owner: Waters of Summit City-Fort Wayne
Officers: Jerry Kemper
Most recent change in ownership: Beverly Healthcare, Jan. 1, 2007
Status: for profit
Administrator: Carmela Tuttle
Hire date: July 13, 2007
Sprinkler system: full
Resident rooms with smoke alarms: not available
Facility fire safety violations in past year: 4
Average fire violations in Indiana: 4
Beds: 88
Census: 69 as of May 16
Most recent annual survey: May 16, 2008
In substantial compliance? No
When compliance met: July 20
Deficiencies found in Levels D-L:**

8D; 2E
D Level:
 ◆ Housekeeping/maintenance: failure to ensure a resident's nightstand was functional. The drawer front was missing on one drawer and handles missing on the other drawer, preventing the resident from using the nightstand. A family member said the drawers had been broken at least a week, although facility policy was that maintenance personnel were to check maintenance/repair slips regularly. Surveyors noted the broken nightstand May 13 but it still had not been repaired by May 16.
 ◆ Comprehensive care plans – failure to develop a care plan for one resident's activities of daily living. The resident needed extensive assistance, yet no care plan was written as to how staff would provide assistance. Facility policy is that care plan would be developed within seven days of admittance.
 ◆ Comprehensive care plans – Failure to follow one resident's care plan that called for the resident to wear protective geri-sleeves to prevent breakdown of the skin on the elbows and forearms. The doctor ordered the protective sleeves. Staff also failed to follow doctor's orders to use honey

thickening for the resident's liquids and to add high-calorie potatoes to the man's lunch and supper meals to ensure he had additional calories to maintain weight.
 ◆ Nutrition – failure to provide protein supplements for one resident who needed more protein as ordered by the doctor. The resident's menu card said he was to receive the protein supplement and power potatoes but surveyors observed he had French fries instead.
 ◆ Food – failure to follow the speech therapist's recommendations for the above-mentioned resident whose doctor ordered them.
 ◆ Pharmacy services – failure to ensure prescription drugs were secured and that only authorized personnel had access to them. All staff had keys to a supply room where an unlocked refrigerator contained drugs that were to be kept locked. A nursing assistant was observed taking a key out of her pocket and unlocking the drug room, even though state and federal law says drugs and biologicals are to be accessed only by nurses, doctors, pharmacists and qualified medication aides.
 ◆ Clinical records – failure to accurately document one resident's

food intake. The resident had a poor appetite, and the doctors had ordered high-protein power shakes three times a day as well as fortified milk at meals.
E Level:
 ◆ Dignity: failure to promote each resident's dignity during meal times by not providing knives during meal times, drinking glasses, condiments and hot beverages in two dining rooms – residents used the back of spoons to spread butter on bread and had to pick up uncut chicken with their fingers to eat it. Even a resident on the Alzheimer's unit was alert enough to tell surveyors that it bothered her to not have a knife and that she had to eat with her fingers. One resident's husband brought a table knife from home and assisted his wife and other residents by cutting up their food.
 ◆ Accidents and supervision – failure to ensure the second-floor Alzheimer's unit was free of safety hazards. A heater in the beauty shop, used to heat a flat iron for straightening hair, was left plugged in and unsupervised. Residents had ready access to the heater that reached 360 degrees or higher. Surveyors saw one resident walk up to the counter where the heater was sitting. The beautician said she

would lock the door but it had no lock.
Substantiated complaints in 2008: none
Previous year: 5
Substandard quality of care designations in 2008: none
Immediate jeopardy designations in 2008: June 27
Federal Quality Initiative scores:
Staffing hours per resident per day for licensed nursing staff:
 The Waters: 1 hour, 14 minutes
 State average: 1 hour, 24 minutes
 National average: 1 hour 18 minutes
For nursing assistants:
 The Waters: 1 hour, 45 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)
 The Waters: 213
 Statewide average: 193
Overall federal Star Quality Rating*:** 2 out of 5 stars
State licensure actions in 2008: none
Federal actions imposed: federal civil penalty of \$3,500 a day imposed June 27, 2008, and still in effect as of Feb. 1