

## NURSING HOME REPORT

### LIFE CARE CENTER



**Address:** 1649 Spy Run Ave.  
**Phone:** 422-8520  
**Owner:** Life Care Centers of America  
**Officers:** Forrest Preston, Angelena Clayton, J. Stephen Ziegler and Cindy Cross  
**Most recent change in ownership:** None  
**Status:** For profit  
**Administrator:** Stacy L. Mevzek  
**Hire date:** Oct. 26  
**Beds:** 125  
**Census:** 65 as of Aug. 21  
**Sprinkler system:** Full  
**Resident rooms with smoke alarms:** None  
**Facility fire safety deficiencies in**

**past year:** 4  
**Average fire safety deficiencies in Indiana:** 2  
**Most recent annual survey:** Date: Sept. 17-21  
**In substantial compliance?** No  
**When compliance met:** Dec. 19  
**Deficiencies found in Levels D-L:** 6D; 2E  
**D Level:**  
 ♦ Failure to develop individualized care plans to meet nutritional needs for two residents. In one case, a doctor ordered a high-protein drink for a resident with low blood protein levels; the resident began refusing the drink, so the doctor discontinued it, but the resident's blood protein levels remained low, and the facility failed to update nutritional care plans.  
 Another resident with memory problems was to have a clock or watch in view and a calendar easily accessible, as well as objects in her room labeled, but surveyors observed none of that.  
 ♦ Failure to follow doctor's orders to discontinue medications for two

residents. One resident's antipsychotic med was changed from one time daily to "as needed," yet the resident was given daily doses for another 15 days. Another resident's use of an inhaler was increased to four times a day, but there was no record the inhalant was given for five days in September or that it had been increased to four times a day.  
 ♦ Failure to provide adequate dietary interventions for a resident with low blood protein levels.  
 ♦ Failure to prevent use of unnecessary drugs. One resident was given an antipsychotic daily at bedtime and an antidepressant each morning since 2005. Nursing home regulations state reduction in psychotropic drugs must be tried annually. Although nursing notes in March 2007 said the resident was not taking the antipsychotic and the pharmacist had recommended a trial of reduction, no documentation existed for other means attempted to address the resident's behavioral needs or that the medications had

been stopped. The social services director said the resident's behaviors improved soon after she moved to the nursing home.  
 ♦ Failure to follow regulations regarding drug regimen. A gradual reduction of antipsychotic medication was not attempted.  
 ♦ Failure to document daily meal intakes for four residents with weight loss. Of 276 meals served, only 189 meals, or 68 percent, had necessary intake documentation.  
**E Level:**  
 ♦ Failure to provide documentation of administration of pneumonia shots for six residents or that they or their legal representative were provided information on the risks and benefits of the shot.  
 ♦ Failure to follow regulations regarding pharmacy services; expired medications were not removed from two medication carts or from a medication refrigerator.  
**Substantiated complaints as of Oct. 1:** 1 Level D, relating to failure to follow doctor's orders to do blood testing of one resident; other

deficiencies at D level were found during the complaint investigation: failure to assess respiratory status of a resident following breathing treatments; failure to ensure nurses documented changes in a resident's condition.  
**Previous year:** 4  
**Federal Quality Initiative scores:**  
**Staffing hours per resident per day for licensed nursing staff:** Life Care Center: 1 hour, 35 minutes  
 Statewide average: 1 hour, 24 minutes  
 National average: 1 hour, 18 minutes  
**For nursing assistants:** Life Care Center: 1 hour, 56 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)  
 Life Care Center: 252  
 Statewide average: 191  
**State licensure actions this quarter:** None  
**Federal actions imposed:** None

### REGENCY PLACE OF FORT WAYNE



**Address:** 6006 Brandy Chase Cove  
**Phone:** 486-3001  
**Owner:** Kindred Nursing Centers Limited Partnership, Louisville, Ky.  
**Officers:** William Altman, Kimberly Beach, Lane Bower, Richard Chapman, Richard Lechleiter, Russell Ragland, Donald Robinson and Arthur Rothgerber  
**Most recent change in ownership:** Hillhaven/Indiana Partnership prior to May 1, 1998  
**Status:** For profit  
**Administrator:** Susan K. Ebbing  
**Hire date:** Oct. 13, 2000  
**Beds:** 160  
**Census:** 148 as of July 28  
**Sprinkler system:** Full  
**Resident rooms with smoke alarms:** 80 of 80 with system-based smoke alarms  
**Facility fire safety deficiencies in past year:** 1  
**Average fire safety deficiencies in Indiana:** 2  
**Most recent annual survey:** Date: Aug. 19-24  
**In substantial compliance?** No  
**When compliance met:** Nov. 20  
**Deficiencies found in Levels D-L:** 7D; 1E

**D Level:**  
 ♦ Failure to ensure privacy for a resident by staff not knocking on the resident's door prior to entering.  
 ♦ Failure to develop interventions and approaches for two residents with swallowing difficulties.  
 ♦ Failure to ensure the care plan for feeding one resident with a history of aspirating foods and liquids; resident initially was to receive one-to-one assistance in eating and to eat and drink teaspoon-size portions and to be upright when eating. The doctor then ordered the resident to have half-teaspoon portions, but surveyors observed the resident sitting in the dining room, wheelchair tilted back, feeding himself entire forks full of food, with 5-15 seconds between bites. Staff gave the man sips of drink from an 8-ounce cup, and staff did not encourage the resident to swallow between bites or after drinking. He was also given a graham cracker snack and an 8-ounce glass of juice, which he fed/drank on his own without staff observation.  
 ♦ Failure to ensure a wheelchair cushion was properly inflated for a resident with an open pressure sore on her tailbone. When surveyors requested the woman be taken to the physical therapy department to have the wheelchair cushion checked, as the woman moved from her wheelchair to a stationary chair, she said, "It hurts. It feels like nails." The therapist said the cushion was not inflated correctly.  
 ♦ Failure to ensure care plans were followed for toileting one resident

with bladder incontinence. The care plan said she was to be toileted before and after meals and at bedtime and was totally dependent on staff for transfers from wheelchair to toilet. The resident was observed about 4 p.m. at the nurses' station with her hands in her pants, asking for toilet paper. She told another nearby resident she had to go to the bathroom. A nurses aide walked by the resident. Then she was taken to the dining room, where she remained in her wheelchair until 6:30 p.m. From 4-6:30 p.m., no one took her to the bathroom.  
 ♦ Failure to ensure the care plan was followed for a resident with too quick weight loss and who had low protein levels in her blood. Surveyors observed at several meals the scant amount of food she ate. When surveyors twice asked for the woman's most recent albumin (blood protein) lab reports, the facility failed to provide them.  
 ♦ Failure to provide pain medication for a resident who was to get the medicine routinely. The resident was to be given the pain med three times a day; between April 16-25, there was no record it was given. At least one day, a different narcotic pain medicine was given to the resident because the prescribed one "was not available," records showed. Although the initially prescribed drug was not available starting April 16, a doctor's order to discontinue that drug, found in the chart, was dated April 25. Eight of nine residents queried by surveyors said the facility often ran

out of routine meds; even over-the-counter medications such as acetaminophen were not always available, they said.  
**E Level:**  
 ♦ Failure to store food under sanitary conditions: single custard pie servings uncovered on the counter; on Aug. 19, partially covered sandwiches dated Aug. 11 were seen in a walk-in refrigerator; individual serving bowls of ice cream were in the walk-in freezer, uncovered and undated. Ice cream in individual cups that was to be served at a meal had already melted.  
**Substantiated complaints as of Oct. 15:** 3; two were not at the level of seriousness to receive deficiencies; the third merited these deficiencies: 1D; 1J; and 1K; all were related to the failure to follow doctor's orders and care plans for the dietary supplements and feeding precautions for three residents with nutritional needs and/or swallowing difficulties. One resident was to have a regular diet with ground meat and peanut butter at every meal, plus high-caloric drink supplement, which surveyors noted she did not receive. Her food was pureed. The woman's weight dropped from 102 to 88 pounds between January and February 2007. Another resident at high risk for choking or aspirating food/drink was observed eating multiple meals with no supervision, although her care plan called for it. Once, the woman was seen eating lunch in bed and attempting to drink from a cup. "The rim of the cup was positioned above her upper lip, with

her tongue protruding below the rim," the report stated. The facility failed to provide juice for a third resident. Another resident, who also was to eat meals supervised, needed help to eat, but surveyors saw her food tray delivered and removed without her eating. The woman later required admittance to a hospital, where tests showed her fluid/protein levels were significantly abnormal.  
**Previous year:** 6  
**Immediate jeopardy and standard quality of care designations:** In effect Oct. 9 due to issues listed in the above complaint. Immediate jeopardy status removed Oct. 15.  
**Federal Quality Initiative scores:**  
**Staffing hours per resident per day for licensed nursing staff:** Regency Place: 1 hour, 19 minutes  
 Statewide average: 1 hour, 24 minutes  
 National average: 1 hour, 18 minutes  
**For nursing assistants:** Regency Place: 1 hour, 58 minutes  
 State average: 2 hours  
 National average: 2 hours, 18 minutes  
**National Nursing Home Compare Score (based on 3 years of data):** (The lower the score, the better)  
 Regency Place: 356  
 Statewide average: 191  
 State licensure actions for 2007: None  
**Federal actions imposed:** Federal civil money penalties: \$100/day from Oct. 15-Nov. 19; \$4,650/day from Oct. 11-Oct. 14; \$100/day from May 31-June 26; \$150/day from Nov. 2, 2006-Jan. 4, 2007

### RENAISSANCE VILLAGE



**Address:** 6050 S. County Road 800 E-92, Fort Wayne  
**Phone:** 625-3545  
**Owner:** Renaissance Health Care LLC, Fort Wayne  
**Officers:** Dr. Michael Mohrman, Bill Ehinger and Gary Probst  
**Most recent change in ownership:** Prior to Sept. 22, 1993, was Renaissance Health Care Corp., Fort Wayne  
**Status:** For profit  
**Administrator:** Deborah I. Mills  
**Hire date:** Jan. 19, 1998  
**Beds:** 96  
**Census:** 88 as of Aug. 2  
**Sprinkler system:** Full  
**Resident rooms with smoke alarms:** 8 of 49, all with battery-operated alarms  
**Facility fire safety deficiencies in past year:** 1  
**Average fire safety deficiencies in Indiana:** 2  
**Most recent annual survey:** Date: July 30-Aug. 3  
**In substantial compliance?** No  
**When compliance met:** Sept. 5

**Deficiencies found in Levels D-L:** 4D  
**D Level:**  
 ♦ Failure to do a comprehensive assessment to ensure a resident's bladder continence was assessed in a timely manner; also failure to ensure a decline in bowel continence was adequately assessed.  
 The April 4 Minimum Data Set, or MDS, which is a federally mandated quarterly assessment of each resident, said one resident was usually continent of bowel and frequently incontinent of bladder; by June 28, the resident was frequently incontinent of bowel. Although bladder incontinence and bowel constipation issues were addressed in the resident's medical record, no notes were made in regard to the bowel incontinence.  
 On July 31, a nurse manager told surveyors a particular resident was usually continent of bowel/bladder and toileted himself. Assessment notes dated Feb. 9, 2007, stated the resident was totally continent of bowel/bladder. Yet by May 9, the assessment record showed the resident was now occasionally incontinent of bladder. The bowel/bladder maintenance plan showed from June 1-12, the resident had six episodes of bowel incontinence, yet the June 6 quarterly assessment records said the "resident remains continent of

bowels." No documentation was found for reassessment of the reasons for bowel incontinence.  
 ♦ Failure to ensure assessment accurately reflects the resident's status; clinical records for two residents failed to show they had been bathed during the three-month assessment period. A staff member who tracks and submits the federally mandated quarterly assessments said she knew the residents had been bathed during the time periods in question. She told surveyors nurses entered the wrong coding for the MDS paperwork and the electronic data system would not let her correct the errors. The activities of daily living (ADL) records of the residents in question showed the residents received showers at least twice a week, the minimum allowable under state/federal regulations.  
 ♦ Failure to follow doctor's orders for use of a breathing machine for one resident who had been admitted to the facility from a hospital, then a month later readmitted to the hospital, then returned to the facility 10 days later. The resident's diagnoses included congestive heart failure, severe chronic obstructive pulmonary disease and pneumonia. Hospital discharge orders stated the man was to use a respiratory aid called a BiPAP machine, which blows pressurized air through a tube into a face mask, keeping the airway

open. With a BiPAP, pressure is different on inhalation and exhalation. According to records, the facility did not have a BiPAP when the resident returned to the facility Dec. 6, so a CPAP machine was used instead. CPAP is similar to BiPAP but delivers air at a constant pressure. Nursing notes state man used a BiPAP from Dec. 6-10. Yet an invoice from the medical equipment company showed the facility did not get the BiPAP until Dec. 8. A nurse manager said she did not realize the facility had no BiPAP until Dec. 8, and used the CPAP the family provided until the BiPAP was delivered. Notes also state the resident refused to keep the mask on of either machine. On Dec. 10, the resident was readmitted to a hospital for low oxygen levels.  
 ♦ Failure to ensure nurse aides demonstrated competency in skills and techniques necessary to care for residents. Facility policy said staff were to use an assistive device called a gait belt, which wraps around a resident's waist and offers aides or nurses a "handle" when helping residents move around. Records showed two aides on July 28 unsuccessfully attempted to transfer one "totally dependent" resident from her bed to commode. The woman ended up with her upper body on the bed and her lower half "still sitting on commode." The aides had to lower

the resident to the floor before successfully helping her up to the bed again. The woman complained of right hip pain, but X-rays showed no break. An incident report was filed, and "disciplinary action" was taken against the two aides, records show.  
**Substantiated complaints as of Aug. 3:** 1 D Level, which related to the nursing home's failure to supply a doctor-ordered BiPAP machine when a resident was readmitted after being hospitalized.  
**Previous year:** None  
**Federal Quality Initiative scores:**  
**Staffing hours per resident per day for licensed nursing staff:** Renaissance Village: 1 hour, 28 minutes  
 Statewide average: 1 hour, 24 minutes  
 National average: 1 hour, 18 minutes  
**For nursing assistants:** Renaissance Village: 2 hours, 19 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)  
 Renaissance Village: 52  
 Statewide average: 191  
**State licensure actions this quarter:** 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

**Most recent change in ownership:** None  
**Status:** Nonprofit  
**Administrator:** B. Daniel Carr  
**Hire date:** Nov. 17, 1985  
**Beds:** 58 state-certified beds; 12 Medicare beds, which are the only ones federally inspected for Medicare certification; no Medicaid beds; 361 total beds in facility.  
**Census:** 11 in Medicare unit as of Oct. 2  
**Sprinkler system:** Full  
**Resident rooms with smoke alarms:** None  
**Facility fire safety deficiencies in past year:** 3

**Average fire safety deficiencies in Indiana:** 2  
**Most recent annual survey:** Date: Sept. 17-21  
**In substantial compliance?** Yes  
**Deficiencies found in Levels D-L:** None  
**Substantiated complaints as of Sept. 21:** 1, which resulted in the following deficiencies: 4D; 2G; problems related to failure to thoroughly investigate an incident in which a female resident's feeding tube was allegedly pulled out during rough handling by an aide; failure to routinely assess the same resident's bowel sounds and follow her care

plan regarding the tracking of her bowel movements; failure to assess competency of the aide who cared for the woman with the feeding tube; and failure to ensure lab results were in the resident's clinical record and that the record was complete and accurately documented.  
**Previous year:** None  
**Federal Quality Initiative scores:**  
**Staffing hours per resident per day for licensed nursing staff:** Towne House: Not available  
 Statewide average: 1 hour, 24 minutes  
 National average: 1 hour, 18 minutes  
**For nursing assistants:**

Towne House: Not available  
 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)  
 Towne House: 126  
 Statewide average: 191  
**State licensure actions this quarter:** None  
**Federal actions imposed:** Civil penalty of \$150/day from June 11-July 9