STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815	

(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
F000000	This visit was for the Investigation of Complaint IN00153043. Complaint IN00153043 Substantiated, no deficiencies related to the allegations were cited. Additional findings were cited at F-282 and F-514. . Survey Dates: July 25, 28 & 29, 2014 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Survey team: Angela Strass, RN Census bed type: SNF/NF: 76 Total: 76 Census payor type: Medicare: 3 Medicaid: 57 Other: 16 Total: 76 Sample: 3 These deficiencies also reflect state	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815	

(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
	findings in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, interview and review of facility documents, the facility failed to ensure physician orders were followed as written for a low blood sugar for 1 resident (C) in a sample of 3 resident records reviewed. Finding Includes: Review of the clinical record for resident (C) on 7/28/14 indicated he was admitted to the facility on 12/21/13 with diagnoses including but not limited to Diabetes Mellitus, End Stage Renal Disease, and Chronic Obstructive Pulmonary Disease. Review of physician orders for resident (C) indicated an order, dated 1/30/14, "If Blood Sugar is less than 60 and resident is responsive give 4 ounces of orange juice and notify MD."	F000282	·Resident C discharged on 07/13/2014 ·All residents have the potential to be affectedby this practice. 100% audit completed of all insulin defendant diabetics' blood sugars to assurethat any blood sugars significantly out of range were reported to the physicianand orders clarified for treatment of significantly low or high blood sugars. ·DON and/or designee (s) will monitor all nurses'notes, MARs, TARs and telephone orders during morning meeting weekly to assurethat any instances of significantly high or low blood sugars were reported tothe physician as well as physicians' orders were followed as written. Alllicensed nursing staff in-service by SDC regarding,following and transcribing physician's orders and assessment, documentation	08/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815	

(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
	On 7/28/14 at 2:00 p.m. review of the nursing notes indicated he following: 7/12/14 at 1600 (4:00 p.m.) - "The writer was called to resident room, by his lady friend stating that she thinks residents blood sugar (bs) was low, when I the writer took residents bs it was 47. Resident was given OJ (orange juice) with sugar, and a can of glucerna (a diabetic drink with slow digestible carbohydrates, which reduces blood sugar spikes), in 30 minutes took residents bs again it was up to 70, resident was responding. Resident IV (intravenous) was started, ATB (antibiotic) for UTI (urinary tract infection). Resident tolerated well will continue to monitor." On 7/29/14 at 10:30 a.m. review of the Facility Policy "Acute Condition changes-Clinical Protocol", dated 12/12, indicated the nursing staff would contact the physician based on the urgency of the situation. For emergencies, they would call or page the Physician and request a prompt response (within approximately one-half hour or less). Interview with the Director of Nursing and the Administrator, on 7/29/14 at 10:45 a.m., indicated the nurse who took care of the resident on 7/12/14 was no		andfollow up on change in condition to be completed by 8-13-2014. ·Audit tool will be reviewed weekly by theExecutive Director for compliance and monthly in the Performance Improvementmeeting for 3 months and quarterly until compliance is achieved, as determinedby the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815	

(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
	longer employed at the facility. Further interview indicated the Nurse Practitioner wrote a progress note, which was not dated, indicating the following: "On 7/12/14 nurse notified me of the low blood sugar on resident (C)." Further interview with the Administrator indicated the concern was the nurse gave the resident sugar in the orange juice and glucerna, which was not indicated on the written physicians order. 3.1-35(g)(2)			
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review, interview and	F000514	·Resident C discharged on	08/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815	

(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
	review of facility documents, the facility failed to ensure documentation of physician notification for 1 resident (C) in a sample of 3 resident records reviewed who had a low blood sugar and an order to notify the physician when blood sugar was below 60. Finding Includes: Review of the clinical record for resident (C), on 7/28/14, indicated he was admitted to the facility on 12/21/13 with diagnoses including but not limited to Diabetes Mellitus, End Stage Renal Disease, and Chronic Obstructive Pulmonary Disease. Review of physician orders for resident (C) indicated an order, dated 1/30/14, "If Blood Sugar is less than 60 and resident is responsive give 4 ounces of orange juice and notify MD." On 7/28/14 at 2:00 p.m. review of the nursing notes indicated he following: 7/12/14 at 1600 (4:00 p.m.) - "The writer was called to resident room, by his lady friend stating that she thinks residents blood sugar (bs) was low, when I the writer took residents bs it was 47. Resident was given OJ (orange juice) with sugar, and a can of glucerna (a diabetic drink with slow digestible carbohydrates, which reduces blood sugar		07/13/2014 ·All residents have the potential to be affectedby this practice. 100% audit completed of all insulin dependent diabetics'blood sugars to assure that any blood sugars significantly out of range werereported to the physician and orders clarified for treatment of significantlylow or high blood sugars. ·DON and/or designee (s) will monitor all nurses'notes, MARs, TARs and telephone orders during morning meeting weekly to assurethat any instances of significantly high or low blood sugars were reported tothe physician as well as physicians' orders were followed as written. Alllicensed nursing staff in-service by SDC regarding, following and transcribingphysician's orders and assessment, documentation and follow up on change in conditionto be completed by 8-13-2014. ·Audit tool will be reviewed weekly by theExecutive Director for compliance and monthly in the Performance Improvementmeeting for 3 months and quarterly until compliance is achieved, as determinedby the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815	

(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
	spikes). in 30 minutes took residents bs again it was up to 70, resident was responding. Resident IV (intravenous) was started, ATB (antibiotic) for UTI (urinary tract infection). Resident tolerated well will continue to monitor." On 7/28/14 at 2:15 p.m., review of physician orders for resident (C) indicated an order, dated 1/30/14, "If Blood Sugar is less than 60 and resident is responsive give 4 ounces of orange juice and notify MD." Review of nursing notes did not indicate any documentation of the physician being notified of the resident's low blood sugar. On 7/29/14 at 10:30 a.m. review of the Facility Policy "Acute Condition changes-Clinical Protocol" dated 12/12, indicated the nursing staff would contact the physician based on the urgency of the situation. For emergencies, they would call or page the Physician and request a prompt response (within approximately one-half hour or less). Interview with the Director of Nursing and the Administrator, on 7/29/14 at 10:45 a.m., indicated the nurse who took care of the resident on 7/12/14 was no longer employed at the facility. Further interview indicated the Nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(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
	Practitioner wrote a progress note, which was not dated, indicating the following: "On 7/12/14 nurse notified me of the low blood sugar on resident (C)." Review of the clinical record for resident (C) did not indicate the nurse had called the physician and/or received any verbal orders. On 7/29/14 at 11:00 a.m. the Administrator was queried about the facility policy for documentation in the clinical record, and indicated there was not a specific policy related to documentation. 3.1-50(a)(1) 3.1-50(a)(2)			