STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 00 / B. WING	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00186954. Complaint IN00186954 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323. Survey dates: November 19 and 20, 2015. Facility number: 000215 Provider number: 155322 AIM number: 100267600 Census bed type: SNF/NF: 57 Total: 57 Census payor type: Medicare: 3 Medicaid: 40 Other: 14 Total: 57 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November	F 0000		

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: 155322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	23, 2015 by 17934.			
F 0282 SS=D Bldg. 00	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 observation, interview and record review, the facility failed to ensure the nursing care plan fall interventions were implemented for 1 of 3 residents reviewed for accidents. (Resident B). Findings include: 1. The clinical record of Resident B was reviewed on 11/19/15 at 9:45 a.m. The record indicated the resident's diagnoses included, but were not limited to, vascular dementia with delusions, depression, hypertension, arterial fibrillation and esophageal reflux. Review of the Quarterly Minimum Data Set (MDS) assessment dated 10/28/15, indicated Resident B was severely cognitively impaired. Resident B was totally dependent for transfers with 2 person assist. During an observation and interview with LPN #1 on 11/19/15 at 9:30 a.m.,	F 0282	Corrective Action for Affected Residents: For affected resident, care plan will bereviewed by IDT to assure that appropriate fall risk care plan is inplace. IDT will ensure that appropriateinterventions are on the CNAs assignment group sheets with care plan review. Corrective Action for Potentially Affected Residents: Any resident determined to be a potentialfall risk will be reviewed by IDT to ensure that appropriate fall risk careplans are in place. CNA group sheetswill be updated by IDT to reflect interventions. Measures for Prevention: All Staff to be in serviced and re-educated onHCP and group assignment sheet policy & procedure. QA for Prevention: Fall risk care plans are reviewed by IDT for each resident with theirquarterly MDS update and assignment sheets are updated weekly and as needed. Staff Development Director or designee will monthlyreview a random sample of resident's health	12/20/2015

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
	155322		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	Resident B was observed sitting in her wheelchair in her room. LPN #1 indicated there were no bed or chair alarms in place. Resident B was observed to have a large, blood filled, hematoma above her left eye on her forehead. She was also observed to have various stages of bruising on under both eyes. During an interview on 11/19/15 at 10:00 a.m., LPN #2 indicated she was unable to find a care plan related to alarms, but knew Resident B had alarms for both the bed and wheelchair. She indicated she documented she had checked the alarms were in working order. Review of a nursing note dated 11/6/15, provided by the SSD (Social Service Designee) on 11/20/15 at 8:30 a.m., indicated the following: "Resident fell forward from wheelchair while in her room. She hit her head and face on floor. 5 x 6 cm [centimeter] elevated bruise/abrasion on L [left] forehead. 1 x 1 cm [centimeter] abrasion to bridge of nose. 1 cm [centimeter] superficial laceration under L [left] eye. NP [nurse practitioner], spouse, and DON (Director of Nursing) notified. N.O. [new order] to hold ASA (aspirin) x 2 days, and neuro checks initiated. Spouse does not want her sent to hospital at this time."		care plans and CNA group sheetsfor accuracy and consistency. Concernswill be reviewed during monthly QA meeting. Systemic changes to be completed by 12/20/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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 the Fall Investigation dated 11/6/15 at 4:20 p.m., indicated "Resident was transferred by lift from bed to wheelchair. Sitting in w/c [wheelchair] in room, fell from wheelchair." The investigation indicated there was not a bed alarm or personal chair alarm on at the time of the fall. Review of a physician's order dated 11/6/15, indicated "hold aspiring x 2 days-resume 11/8/15, neuro checks per policy, to be seen by NP [nurse practitioner] on 11-9-15." The physical examination by the Nurse Practitioner dated 11/9/15, indicated "Approx [approximately] 5 x 6 cm [centimeter] round abrasion, dried red dng [drainage] noted c [with] some scabbing, 1 cm abrasion @ [at] bridge of nose, scabbing over, red, purple bruising noted L [left] eye c [with] edema et [and] some @ [at] R [right] eye c [with] bruising L [left] forehead, tiny resolving abrasion .5 cm [centimeter] under L [left] eye, 0 [zero] drainage." Review of the November 2015 Treatment Administration Record (TAR) for Resident B, indicated "bed and/or chair alarms are tested every shift by applying and releasing pressure to alarm pad to			

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
	155322		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	ensure in working order." Staff documented each shift the bed and chair alarms were in working order from 11/1/15 through 11/19/15. During an interview on 11/19/15 at 3:00 p.m., LPN #3 indicated she was the nurse on duty when Resident B fell. She indicated the resident was just transferred from her bed to her wheelchair and she had gone next door to transfer another resident when the daughter of the roommate yelled for help. She indicated she was not aware Resident B could not be left unattended in her room while she was up in her wheelchair. She also indicated she was signing off the alarms were in working order. During an interview on 11/19/15 at 3:35 p.m., CNA #4 indicated he was on duty at the time of the fall. He indicated Resident B's face swelled up immediately and he applied ice to the resident's face even through dinner. He indicated he was unaware Resident B was not to be left her in room alone when she was up in her wheelchair. During an interview on 11/19/15 at 4:30 p.m., the Director of Nursing (DON) indicated it was not a facility policy if a resident was a fall risk that they could not be left in their rooms alone. She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	indicated it was not on the CNA assignment sheet the resident could not be left alone in her room, but the CNA's have access to all care plans. She indicated she could not answer why the nurses were charting the bed and chair alarms were being checked when they were not in place. She indicated the alarms were a nursing measure and they did not need an order to place the alarms. Review of a Fall Prevention Care Plan, initiated 5/15 and updated 10/15, indicated, "[Name of resident] is at risk for falls r/t [related to] Dementia, A-fib, pacemaker and weakness and unsteady gait. Her primary mode of locomotion is her w/c [wheelchair]; but she is unable to propel self independently." The interventions included, but were not limited to, "Do not leave alone in wheelchair in her room." A Communication Care Plan, initiated 5/1/15 and updated 10/15, indicated, "[Name of resident] has a diagnosis of Dementia....She is severely impaired in her cognitive skills....She is able to answer simple...but for the most part, relies on staff to anticipate and meet her needs....She does not use her call light appropriately and is unable to understand it's usage due to her cognitive loss."			

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
	155322		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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 the current policy titled "Fall Prevention" provided by the Administrator on 11/19/15 at 12:40 p.m., indicated the following: ..."Purpose: To identify residents who are at risk for falls and a plan for a fall prevention program. Procedure: ...C. If the resident is identified to be at risk for fall, initiate a fall prevention care plan. ...H. Fall prevention interventions are added to the nursing assignment group sheets and plan of care. ...J. The Charge Nurses monitor through the 24-hour report as needed and monthly through the narrative progress to care plan goals." This Federal tag relates to Complaint IN00186954. 3.1-35(g)(2)			
F 0323 SS=G	483.25(h) FREE OF ACCIDENT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
Bldg. 00	HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident was not left unattended in a room as a measure to prevent a fall for 1 of 3 residents reviewed for accidents (Resident B). This resulted in severe facial bruising and a large blood filled hematoma on her forehead. Findings include: 1. The clinical record of Resident B was reviewed on 11/19/15 at 9:45 a.m. The record indicated the resident's diagnoses included, but were not limited to, vascular dementia with delusions, depression, hypertension, arterial fibrillation and esophageal reflux. Review of the Quarterly Minimum Data Set (MDS) assessment dated 10/28/15, indicated Resident B was severely cognitively impaired. Resident B was totally dependent for transfers with 2 person assist. During an observation and interview with LPN #1 on 11/19/15 at 9:30 a.m., Resident B was observed sitting in her wheelchair in her room. LPN #1	F 0323	Corrective Action for Affected Residents: For affected resident care plan will bereviewed by IDT to assure that appropriate fall risk care plan is inplace. IDT will ensure that appropriateinterventions are on the CNA group sheets with care plan review. The charge nurse will reinforce appropriateuse of group sheets for resident care when giving report to the CNAs at thestart of each shift. Corrective Action for Potentially Affected Residents: Any resident determined to be a potentialfall risk will be reviewed by IDT to ensure that appropriate fall risk careplans are in place. CNA group sheetswill be updated by IDT to reflect interventions. The charge nurse will reinforce appropriateuse of group sheets for resident care when giving report to the CNAs at thestart of each shift. Measures for Prevention: All Staff to be in serviced and reeducated onHCP and group assignment sheet policy & procedure. CNAs will be required toturn group sheets into Staff Development Director or designee after each shiftworked with signature and date. QA for Prevention: Facility Fall policy will bereviewed and updated as	12/20/2015

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
	155322		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	indicated there were no bed or chair alarms in place. Resident B was observed to have a large, blood filled, hematoma above her left eye on her forehead. She was also observed to have various stages of bruising on under both eyes. During an interview on 11/19/15 at 10:00 a.m., LPN #2 indicated she was unable to find a care plan related to alarms, but knew Resident B had alarms for both the bed and wheelchair. She indicated she documented that she had checked the alarms were in working order. Review of a nursing note dated 11/6/15, provided by the SSD (Social Service Designee) on 11/20/15 at 8:30 a.m., indicated the following: "Resident fell forward from wheelchair while in her room. She hit her head and face on floor. 5 x 6 cm [centimeter] elevated bruise/abrasion on L [left] forehead. 1 x 1 cm [centimeter] abrasion to bridge of nose. 1 cm [centimeter] superficial laceration under L [left] eye. NP [nurse practitioner], spouse, and DON (Director of Nursing) notified. N.O. [new order] to hold ASA (aspirin) x 2 days, and neuro checks initiated. Spouse does not want her sent to hospital at this time." Review of the Fall Investigation dated		needed. Fall risk care plans are reviewed by IDT foreach resident with their quarterly MDS update and assignment sheets are updatedweekly and as needed. Staff DevelopmentDirector or designee will monitor that group assignment sheets are being turnedin at the end of sheets. Concerns willbe reviewed during monthly QA meeting. Systemic changes to be completed by 12/20/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	11/6/15 at 4:20 p.m., indicated "Resident was transferred by lift from bed to wheelchair. Sitting in w/c [wheelchair] in room, fell from wheelchair." The investigation indicated there was not a bed alarm or personal chair alarm on at the time of the fall. Review of a physician's order dated 11/6/15, indicated "hold aspiring x 2 days-resume 11/8/15, neuro checks per policy, to be seen by NP [nurse practitioner] on 11-9-15." Review of a physician's progress note dated 11/9/15, indicated "fall forward out of wc [wheelchair], noticed leaning forward by visitor et [and] fell face forward, hitting forehead, visitor notified nurse." Review of symptoms included, but were not limited to, left eye black with edema, abrasion to forehead, bruising, abrasion on nose between eyes and bleeding with fall from face. The physical examination by the Nurse Practitioner dated 11/9/15, indicated "Approx [approximately] 5 x 6 cm [centimeter] round abrasion, dried red dng [drainage] noted c [with] some scabbing, 1 cm abrasion @ [at] bridge of nose, scabbing over, red, purple bruising noted L [left] eye c [with] edema et [and] some @ [at] R [right] eye c [with]			

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
	155322		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	bruising L [left] forehead, tiny resolving abrasion .5 cm [centimeter] under L [left] eye, 0 [zero] drainage." Review of the November 2015 Treatment Administration Record (TAR), indicated "bed and/or chair alarms are tested every shift by applying and releasing pressure to alarm pad to ensure in working order." Staff documented each shift the bed and chair alarms were in working order from 11/1 through 11/19/15. During an interview on 11/19/15 at 3:00 p.m., LPN #3 indicated she was the nurse on duty when Resident B fell. She indicated the resident was just transferred from her bed to her wheelchair and she had gone next door to transfer another resident when the daughter of the roommate yelled for help. She indicated she was not aware Resident B could not be left unattended in her room while she was up in her wheelchair. She also indicated she was signing off the alarms were in working order. During an interview on 11/19/15 at 3:35 p.m., CNA #4 indicated he was on duty at the time of the fall. He indicated Resident B's face swelled up immediately and he applied ice to the resident's face even through dinner. He indicated he was unaware Resident B was not to be			

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
	155322		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	left her in room alone when she was up in her wheelchair. During an interview on 11/19/15 at 4:30 p.m., Director of Nursing (DON) indicated it was not a facility policy if a resident was a fall risk that they could not be left in their rooms alone. She indicated it was not on the CNA assignment sheet the resident could not be left alone in her room, but the CNA's have access to all care plans. She indicated she could not answer why the nurses were charting the bed and chair alarms were being checked when they were not in place. She indicated the alarms were a nursing measure and they did not need an order to place the alarms. Review of a Fall Prevention Care Plan, initiated 5/15 and updated 10/15, indicated, "[Name of resident] is at risk for falls r/t [related to] Dementia, A-fib, pacemaker and weakness and unsteady gait. Her primary mode of locomotion is her w/c [wheelchair]; but she is unable to propel self independently." The intervention included, but were not limited to, "Do not leave alone in wheelchair in her room." A Communication Care Plan, initiated 5/1/15 and updated 10/15, indicated, "[Name of resident] has a diagnosis of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	Dementia....She is severely impaired in her cognitive skills....She is able to answer simple...but for the most part, relies on staff to anticipate and meet her needs....She does not use her call light appropriately and is unable to understand it's usage due to her cognitive loss." During an observation on 11/20/15 at 9:40 a.m., Resident B had both a bed alarm and chair alarm in her room. Resident B was not in her room at the time of the observation. Review of the current policy titled "Fall Prevention" provided by the Administrator on 11/19/15 at 12:40 p.m., indicated the following: ..."Purpose: To identify residents who are at risk for falls and a plan for a fall prevention program. Procedure: ...C. If the resident is identified to be at risk for fall, initiate a fall prevention care plan. ...H. Fall prevention interventions are added to the nursing assignment group sheets and plan of care. ...J. The Charge Nurses monitor through			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	the 24-hour report as needed and monthly through the narrative progress to care plan goals." This Federal tag relates to Complaint IN00186954. 3.1-45(a)(2)			