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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
R000000	This visit was for the Investigation of Complaints IN00155660 and IN00155794. Complaint IN00155660 - Substantiated. State deficiency related to the allegations is cited at R 0006. Complaint IN00155794 - Substantiated. No deficiencies related to the allegations are cited. Survey Dates: September August 16, 17 & 18, 2014 Facility number: 010235 Provider number: N/A AIM number: N/A Survey team: Angela Strass, RN Census bed type: Residential: 59 Total: 59 Census payor type: Other: 59 Total: 59 Sample: 5	R000000	The following plan of Correction is prepared and submitted by Harbour Assisted Living at Fort Wayne as mandated by the Indiana State Department of Health. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Harbour Assisted Living at Fort Wayne maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations.	

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:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on September 22, 2014 by Randy Fry RN.			
R000006	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, record review, and interview, the facility failed to ensure 1 resident (B) in a sample of 5 resident records	R000006	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** A 30 day notice of transfer/discharge was mailed 10/01/14 to POA for relocation. Also, discussed with	10/04/2014

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	reviewed was living in a safe environment free from falls and injury. Finding includes: On 9/17/14 at 10:00 a.m. review of the clinical record for resident (B) indicated he was admitted to the facility on 1/6/13 with diagnoses including but not limited to History of Falls, Dementia, Parkinson's Disease, Depression and History of Stroke. Review of the resident's medications indicated he was on Warfarin (a blood thinner). Resident (B) lives on the 2nd floor with his wife in an apartment. Both resident (B) and his wife are very confused. On 9/16/14 at 2:00 p.m. resident (B) was observed walking in the Aviary Room with only one shoe on. A personal alarm was noted attached to the chair the resident had been sitting in, but the alarm was not sounding. Another resident was noted to direct the resident back to his chair which he stumbled and fell into the chair. On 9/16/14 at 2:25 p.m. resident (B) was observed to stand up from the chair and begin to ambulate.		family to provide 1:1 care until relocation. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** All high risk fall residents have the potential to be affected and have been reassessed and care plans updated. **MEASURES FOR PREVENTION** All new admissions will continue to be screened for falls and care plans written and implemented as necessary. **QA FOR PREVENTION** The Assisted Living Director or designee will monitor at least monthly, the completion, revision, and implementation of high risk fall care plans and report findings to the Administrator, including any recommendation for relocation of residents due to care needs exceeding the scope of residential care (See Exhibit 1). **EFFECTIVE DATE** The changes are completed and effective by October 4, 2014	

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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 resident's pants were falling down and the alarm was not sounding. This writer informed a staff person the resident was in need of assistance. Observation indicated the alarm was attached to the chair and the resident's sweater vest, which the resident had removed. Staff indicated the alarm was working but the resident had removed his vest. On 9/16/14 at 3:00 p.m. the resident (B) was observed sleeping in a chair in the aviary room. The alarm was noted to be attached to the resident's shirt, and no staff were observed in the area. On 9/17/14 at 9:02 a.m. resident (B) was observed to be taken from the dining room to the Aviary Room by staff and seated in a chair. No alarm was noted to be on the resident. On 9/17/14 at 10:30 a.m. the resident was seated in a chair on the second floor lounge. The resident was observed with an alarm attached to his shirt. The resident's wife was also seated in the lounge in a wheelchair. Observations of the second floor indicated there were no staff in the			

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	hallways. Observation of the staircase from the first to the second floor indicated the stairs to be very wide, with many steps from the first to the second floor. Conversation with staff indicated they call this the "Grand Staircase." The resident and his wife were seated in the lounge which was behind the staircase on the second floor. Review of the clinical record for resident (B) indicated the following nursing notes: 4/29/14 at 8:30 p.m. - "Ambulating in room without walker and lost balance and fell. Denies hitting head. No apparent injuries. Daughter, Physician and Director of Nursing notified." 5/6/14 at 12:00 p.m. "Resident was trying to back up for another resident to go through and fell onto buttocks. No injuries noted." 7/30/14 at 1:45 p.m. "Staff found resident sitting on floor in front of reclining chair in room. Unable to clearly understand how resident fell. Spouse had a wood table in front of her which was flattened on the floor. No apparent injuries.			

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	Daughter, Physician and Executive Director notified." 7/30/14 at 5:00 p.m. - "Staff found resident lying on bed with slacks off and slacks draped over walker at foot of bed. Resident has a fresh abrasion on left knee which is bleeding, evidence of a fall. Resident denies falling. Slacks have no blood on left leg. Left knee ecchymotic. Daughter, Physician and Executive Director notified." 8/5/14 at 5:30 p.m. - "Staff found resident trying to go down back stairs again. CNA (Certified Nursing Assistant) says he "literally caught resident as resident had front wheels of walker on top stair and about to go down stairs." Writer notified POA (Power of Attorney) resident had been caught doing this. Family now aware." 8/13/14 at 8:00 p.m. - "Ambulating in room without walker. Lost balance and sat on floor. Range of motion x 4 without complaints of pain. or discomfort. Did not hit head, no apparent injuries. Daughter and Physician notified." 8/16/14 at 6:30 p.m. - "Resident			

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	attempted to switch chairs in living room of apartment. According to the wife, when he lost his balance and landed on his bottom. Active range of motion to all extremities. No complaints of pain or discomfort. Resident reopened 2 areas on forehead that were scabbed over. Daughter, Physician and Executive Director notified." 8/20/14 at 7:00 p.m. - Found lying on floor in kitchen area on left side. Small cut above left eye. Denies any pain. Range of motion times 4 without complaints. Area above left eye cleaned with soap and water dry dressing applied. Says was ambulating without walker and lost balance. Daughter and physician notified. Daughter declines sending resident to emergency room for evaluation. Will monitor resident closely. Head injury monitoring initiated. Daughter and Physician notified." 8/23/14 at 12:00 a.m. - "Resident up wandering room at this time. Assisted to bathroom with assist of 1. Very confused and unsteady. Up to bathroom every 2 hours and as needed. Incontinent of bladder. Will continue to monitor due to fall risk."			

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	8/27/14 at 3:15 p.m. - "Resident stated slid off seat on walker onto bottom on floor in room. Range of motion times 4 without complaints of pain or discomfort. Has 2 skin tears to back of right hand. Cleansed with soap and water and dry dressing applied. Did not hit head. Daughter and physician notified. Will monitor resident." 9/9/14 at 9:00 p.m. - "Notified by CNA resident fell. Patient found on floor sitting up against bathroom door in resident apartment. Resident could not tell writer what happened. No injuries noted. Full range of motion to all extremities. No complaints of pain or discomfort noted. Daughter, Physician and Director of Nursing notified. Will continue to monitor. " 9/10/14 at 2:15 p.m. Resident trying to ambulate in room and lost balance and fell onto the floor. Resident not able to ambulate without staff assistance. No apparent injuries. Range of motion times 4 without complaints of pain or discomfort. Head injury monitoring initiated. Daughter, Physician and Executive Director notified."			

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	9/11/14 at 7:00 p.m. - " Resident fell in room. Unable to say what happened. No apparent injuries. Range of motion times 4 without complaints. Denies any pain. Head injury monitoring. Daughter, Physician and Director of Nursing notified." Interview with staff #2 on 9/17/14 at 2:50 p.m. indicated resident (B) falls often. Staff #2 indicated they keep the resident on the first floor with an alarm. Staff #2 indicated the alarm can be heard if the staff are close to the room which the resident is sitting. If staff are down the hall or on the 2nd floor it is hard to hear the alarm. Staff #2 indicated the resident is very confused and thinks the second floor stairwell door is the door to his garage. During the interview resident (B's) alarm was sounding and staff #2 had to leave to assist the resident. Interview with staff #1 on 9/17/14 at 3:10 p.m. indicated resident (B) falls all of the time. Staff #1 indicated the resident has attempted to go down the stairs. Staff #1 indicated the resident's wife is very confused and often			

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	tells resident (B) to do things which he is not able to do. During the interview the resident's alarm was sounding and the staff #1 had to leave the room to assist the resident. Interview with the complainant on 9/16/14 indicated a concern resident (B) was in an unsafe environment. The complainant indicated the resident was very confused, often fell and the complainant had witnessed the resident walk down the "Grand Staircase" by himself. The complainant stated "I do not know how he walked down those stairs without falling." Interview with the Director of Nursing on 9/18/14 at 1:45 p.m. indicated resident (B) is a fall risk. She indicated they had spoken to the family about rearranging the furniture in the resident's room, but the family did not want to rearrange the furniture. The Director of Nursing (DON) indicated staff had observed the room and recommended to the family to rearrange the room to make it more safe for the resident. Further interview with the DON indicated the resident had been seen by			

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 09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(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
	physical therapy on 6/26/14 at which time he received therapy and was discharged with the use of a walker. The DON indicated the resident had been seen several times by the physician and the nurse practitioner who had ordered laboratory work and urinalysis. The DON stated they had done everything medically to determine why the resident was falling so often.			