

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155828	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE OF FORT WAYNE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 5250 HERITAGE PARKWAY FORT WAYNE, IN 46835
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F 0000 Bldg. 00	<p>This visit was for an annual Recertification and State Licensure Survey. This visit included a State Residential Licensure survey.</p> <p>Survey dates: March 9, 10, 11, 14, 15, and 16, 20126.</p> <p>Facility number: 012931 Provider number: 155828 AIM number: 201278730</p> <p>Census bed type: SNF: 33 SNF/NF: 10 Residential: 22 Total: 65</p> <p>Census Payor type: Medicare: 6 Medicaid: 10 Other: 27 Total: 43</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on March 18, 2016 by 17934.</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was informed of a resident's low oral fluid intake, which resulted in the</p>	F 0157	Please note that the physician was indeed notified of the decreased fluid intakes as indicated by a physician's order for IV fluids for resident #59 All	04/01/2016

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	<p>resident requiring intravenous fluids, for 1 of 1 residents reviewed for hydration (Resident #59).</p> <p>Findings include:</p> <p>The record for Resident #59 was reviewed on 3/14/2016 at 9:30 A.M. Diagnoses included, but were not limited to, metastatic malignant endometrial adenocarcinoma, intestinal obstruction, and hypertension.</p> <p>Physician orders for Resident #59 indicated the resident was prescribed Furosemide (medication used to treat hypertension and/or edema by eliminating excess fluid from the body) 40 milligrams once daily and potassium chloride 10 milliequivalents (potassium supplement) twice daily.</p> <p>An admission progress note by the facility Registered Dietitian (RD), dated 2/4/2016 at 1:37 P.M., indicated Resident #59's intakes were poor, with averages of 0-25% of meals consumed. The note also indicated the resident reported no issues with chewing or swallowing. The note further indicated Resident #59 was assessed as requiring 1380 cc (cubic centimeters) of fluids daily. The note indicated "(Resident's name) dx (diagnoses) of intestinal obstruction and</p>		<p>residents with decreased intakes will be reviewed for possible signs and symptoms of dehydration and symptoms of dehydration Any resident with noted signs/symptoms of dehydrations ill be seen by the dietician as well as the physician for recommendation The family will also be notified of any findings/interventions Nutrition at Risk Notes and Dietary Recommendations, by the consulting Dietician, will be reviewed weekly to identify other residents with the potential for dehydration Dietician recommendations will be reviewed and communicated with the physician for needed orders and other recommendations Licensed nurses will be in-serviced on the signs and symptoms of dehydration and physician notification of condition change (Attachment A) QA monitoring will be completed during morning IDT as well as weekly Nutrition as Risk meetings All residents noted to be at risk for dehydration will be discussed and monitored for continued risk and/or resolution All concerns will be reviewed a the quarterly QA meeting for further recommendations (Attachment B)</p>	

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	<p>poor intakes increase her risk for weight loss and dehydration."</p> <p>A "Nutritional Risk Assessment-Alternate" completed by the RD, dated 2/4/2016, indicated Resident #59 consumed less than 1000 cc of oral fluids daily.</p> <p>Fluid consumption intake records for Resident #59 for February 2016 were provided by the facility Director of Nursing Services (DNS) on 3/14/2016 at 1:30 P.M. The intake record indicated the resident had received 720 cc of fluid on 2/4/2016, 960 cc of fluid on 2/8/2016, and 300 cc of fluid on 2/13/2016. There was no other documentation of amount of fluids consumed on the resident's fluid intake record.</p> <p>A Medication Administration Record (MAR) for February 2016 indicated Resident #59 started receiving Boost (nutritional supplement) twice daily on February 11, 2016. The MAR indicated the resident consumed 240 cc of Boost on 2/11/2016, 287 cc on 2/12/2016, 480 cc on 2/13/2016, 237 cc on 2/14/2016, 287 cc on 2/15/2016, 100 cc on 2/16/2016, 471 cc on 2/17/2016, and 120 cc on 2/18/2016.</p> <p>Nurse's notes indicated the Resident was</p>			

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	<p>seen by the physician on 2/9/16 and on 2/10/16 by a Nurse Practitioner.</p> <p>A progress note by the physician, dated 2/18/2016 at 5:41 P.M., indicated "Pt (patient) with confusion. Appears to be coughing. Can't provide much history. HX (history) is limited." The progress note indicated the plan was to obtain laboratory tests (complete blood count and comprehensive metabolic profile), a chest x-ray, and a urinalysis and to start intravenous fluids. The note further indicated "Based on labs and x ray results, further steps will be initiated." The note also indicated the resident's prognosis was guarded.</p> <p>A nursing progress note, dated 2/18/2016 at 6:24 P.M., indicated orders had been received from the physician to start intravenous fluids of normal saline (fluid used to treat dehydration).</p> <p>A physician progress note, dated 2/19/2016 at 8:28 A.M., indicated Resident #59 was seen by the physician for a follow up visit. The note indicated the resident was still very weak. The note further indicated the resident's family had declined aggressive treatment in the past, but the physician had been informed the resident's family was considering hospice. The note indicated</p>			

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	<p>the antihypertensive medications were to be held and the physician was waiting for the results of the comprehensive metabolic profile.</p> <p>A laboratory report, with a collection date of 2/19/2016 at 10:35 A.M. and reported date of 2/19/2016 at 11:23 A.M., indicated a blood urea nitrogen (an indicator of hydration status and kidney function) level of 79 mg/dL (milligrams per deciliter) with a normal reference range of 7-18 mg/dL and a Creatinine (an indicator of kidney function) level of 5.83 mg/dL with a normal reference range of 0.61-1.10 mg/dL. The report also indicated a potassium level of 9.0 mmol/L (millimole per liter, used in medicine to measure concentrations of substances in blood) with a normal reference range of 3.6 - 5.1 mmol/L.</p> <p>A nursing progress note, dated 2/19/2016 at 11:08 A.M., indicated the nurse had texted the nurse practitioner (NP) to advise her that the resident had pulled the IV.</p> <p>A progress note dated 2/19/2016 at 11:10 A.M. indicated the NP texted back to the nurse asking if the lab results were available.</p> <p>A progress note dated 2/19/2016 at 11:24</p>			

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	<p>A.M. indicated the nurse texted back to the NP regarding the elevated potassium level.</p> <p>A note dated 2/19/2016 at 11:30 A.M. indicated the NP texted back to the requesting the nurse to call her as soon as possible.</p> <p>A nursing progress note, dated 2/19/2016 at 12:05 P.M., indicated the nurse called the NP with the results from the comprehensive metabolic profile and orders were received to continue the IV fluids. The note also indicated the resident was refusing to eat or drink and the family declined sending the resident to the hospital.</p> <p>The facility DNS was interviewed on 3/16/2016 at 10:00 A.M. During the interview, the DNS indicated the nursing staff had been routinely monitoring the resident for signs and symptoms of dehydration, but there was no further documentation to show fluid consumption for Resident #59. The DNS indicated meal consumption records only indicated the percentage of meals consumed, but did not indicate how much fluids the resident consumed at meals. The DNS indicated the facility staff did not routinely document the amount of fluids consumed by residents unless</p>			

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	<p>intakes were ordered to be monitored by the physician. The DNS indicated Resident #59 had been resistant to consuming fluids.</p> <p>CNA #5 was interviewed on 3/16/2016 at 11:20 A.M. During the interview, CNA #5 indicated Resident #59 had often refused fluids, except for coffee, but she would chew ice chips at times.</p> <p>The DNS was interviewed on 3/16/2016 at 11:15 A.M. During the interview the DNS indicated there was no documentation in Resident #59's clinical record to indicate the physician or nurse practitioner had been notified of the resident's decreased oral fluid intake between 2/10/16 and 2/18/2016.</p> <p>An undated facility policy entitled "Change in Resident Condition or Status" was provided by the DNS on 3/16/2016 at 11:40 A.M. The policy indicated "The charge nurse will notify the resident's attending physician when....There is a significant need to alter the resident's treatment."</p> <p>3.1-5(a)(3)</p>			

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to initiate a care plan to reduce the risk of falls for one of three resident's (#66) reviewed for falls.</p> <p>Findings include:</p> <p>An interview with LPN #1 on 3/10/16 at</p>	F 0279	<p>It is important to note that the Heritage of Fort Wayne had already identified this issue as a concern and had a Quality Improvement plan in place prior to the survey and this survey finding The Heritage of Fort Wayne's plan of correction for this finding was shared with the survey team when they noted the</p>	04/01/2016

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	<p>1:53 P.M., indicated Resident #66 had a fall on 2/16/16 at the facility which resulted in a femur fracture.</p> <p>Review of Resident #66's record on 3/11/16 at 9:15 A.M. indicated the resident was admitted to the facility on 2/12/16 with diagnoses including, but not limited to, Alzheimer's disease, cognitive communication deficit, muscle weakness and a history of falling.</p> <p>On 2/12/16, a Morse Fall Scale Assessment was completed and indicated a score of 55, which is a high risk for falling. The instructions section indicated "Fall Risk is based upon Fall Risk Factors and is more than a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, quarterly, at change of condition, and after a fall. The assessment indicated the resident had: a history of falling; gait was normal/bedrest/wheelchair; ambulatory aid was none/bedrest/wheelchair/nurse assist; mental status was overestimates or forgets limits.</p> <p>An interview with RN #2, on 3/11/16, at 10:11 A.M., indicated the resident was admitted to the facility on 2/12/16 which was a Friday, and the facility should have started an interim care plan upon</p>		<p>concern and there have been no other issues of this nature Resident #66 was assessed prior to admission and after admission for areas of concern regarding her care and services to be provided A chart review has been completed to ensure all care areas have been addressed and are up-to-date All residents admitted within the past month will be reviewed to ensure they have initial care plans for any areas of risk noted in their admission assessments Licensed Nurses will be in-serviced regarding the implementation of initial care plans If admitted Friday through Sunday the weekend supervisor will be responsible for monitoring the initiation of admission care plans and any interventions needed (Attachment C) All new admissions will be monitored weekly by the IDT during morning QA meetings to ensure all admission documentation is in place Any concerns will be reviewed at the quarterly QA committee meeting for further recommendations (Attachment D)</p>	

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F 0282 SS=D Bldg. 00	<p>admission. RN #2 did not believe an interim care plan was implemented before 2/15/16. RN #2 indicated fall interventions should have been added for Resident #66 based on being a high fall risk as indicated by the Morse Fall Assessment of 2/12/16.</p> <p>An interview with the Administrator (Admin), on 3/11/16, at 10:15 A.M. indicated Resident #66 did not have an interim care plan upon admission. The Admin indicated Resident #66 should have had an interim care plan upon admission on 2/12/16.</p> <p>On 3/14/16 at 2:03 P.M., the DNS provided an undated policy for Resident Care Plans. Under General Guidelines: "An initial nursing care plan for the resident will be written and implemented upon admission.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>			

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to obtain laboratory tests as ordered by the physician for 1 of 1 residents reviewed for hydration (Resident #59) and for 1 of 5 resident's reviewed for unnecessary medications (#47) The facility also failed to follow physician's orders for medication for 1 of 5 residents reviewed for unnecessary medications (Resident #17).</p> <p>Findings include:</p> <ol style="list-style-type: none"> The record for Resident #59 was reviewed on 3/14/2016 at 9:30 A.M. <p>A physician's order, dated 1/31/2016, indicated a comprehensive metabolic profile and complete blood count were to be obtained on 2/7/2016.</p> <p>A review of Resident #59's clinical record did not indicate the laboratory tests had been obtained as ordered.</p> <p>The facility Director of Nursing Services (DNS) was interviewed on 3/16/2016 at 10:00 A.M. During the interview, the DNS indicated she had reviewed Resident #59's record and could not</p>	F 0282	<p># 1 Any resident noted with a missed lab order will have their physician notified and any recommended follow-up completed A report of all physician lab orders for the past 3 months will be run and cross-checked with resident charts to ensure all physician lab orders have been followed Licensed nurses have been in-serviced on the procedure for obtaining lab orders, lab draws, lab results and all follow-up orders (Attachment E) All labs will be monitored for completion; entering physician orders, lab notification of draws, and lab results with physician recommendations weekly at IDT QA meetings, then monthly for 3 months, then quarterly Any concerns will be addressed at the quarterly QA meetings for further recommendations (Attachment F) # 2 A chart review will be completed for resident #17 to ensure all other physician orders have been followed A report of all physician lab orders for the past 3 months will be run and crosschecked with resident charts to ensure all physician orders have been followed Licensed nurses have been in-serviced on the procedure for obtaining, entering, following, and completing physician orders</p>	04/01/2016

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	<p>locate the laboratory tests. The DNS further indicated the lab had no record of performing the tests. The DNS further indicated the tests should have been obtained as ordered by the physician.</p> <p>2. The record for Resident #17 was reviewed on 3/14/2016 at 2:00 P.M.</p> <p>Diagnoses included, but were not limited to, hypothyroidism.</p> <p>A current physician's order review sheet indicated Resident #17 had been prescribed levothyroxine (medication used to treat hypothyroidism) 137 mcg (micrograms) daily on 11/28/2015.</p> <p>A physician's order, dated 12/14/2015, indicated levothyroxine 137 mcg daily was discontinued on that date. A notation on the order indicated the reason for the discontinuation was because the dose was to be increased due to an elevated TSH (a lab test to measure thyroid stimulating hormone levels).</p> <p>An undated physician's order indicated a TSH level was to be obtained on 1/7/2016.</p> <p>A Medication Administration Record for December 2015 for Resident #17 indicated levothyroxine 137 mcg daily</p>		<p>(Attachment E) All physician orders will be monitored weekly through IDT QA meetings for one month then monthly for 3 months, then quarterly. All concerns will be addressed at the quarterly QA meetings for further recommendations (Attachment F) #3 A chart review will be completed for resident #47 to ensure all other physician lab orders have been followed. A report of all physician lab orders for the past 3 months will be run and crosschecked with resident charts to ensure all physician lab orders have been completed. Licensed nurses have been in-serviced on the procedure for obtaining lab orders, lab draws, lab results, as well as further follow-up orders (Attachment E). All labs will be monitored for completion, entering physician orders, lab notification of draws, and receipt of lab results with any further follow-up weekly at IDT QA meetings, then monthly for 3 months, then quarterly. Any concerns will be addressed at the quarterly QA meetings for further recommendations (Attachment F).</p>	

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	<p>had been discontinued on 12/14/2015. There was no indication a new dose of levothyroxine had been started at that time.</p> <p>A laboratory report, dated 1/7/2016, indicated a TSH level of 61.88 uIU/ml (International Units per milliliter) with a normal reference range of 0.30 - 3.80 uIU/ml, indicating a hypothyroid state.</p> <p>A physician's order, dated 1/8/2016, indicated levothyroxine 150 mcg daily was started by the physician.</p> <p>A Medication Administration Record for January 2016 for Resident #17 indicated the resident had not received any levothyroxine in January 2016 until January 9, 2016.</p> <p>The facility Director of Nursing Services (DNS) was interviewed on 3/15/2016 at 8:20 A.M. During the interview, the DNS indicated the levothyroxine should not have been discontinued on 12/14/2015 without starting a new dose.</p> <p>#3. Resident #47's record was reviewed on 3/14/16 at 2:00 P.M.. The record indicated a laboratory test, basic metabolic profile (BMP) was ordered by a physician to be completed on 10/15/16. Review of the record indicated the BMP</p>			

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F 0323 SS=G Bldg. 00	<p>was not obtained on 10/15/16.</p> <p>An interview with the Director of Nursing Services (DNS) on 3/15/16 at 1:58 P.M. indicated the BMP for Resident #47 was missed by the lab. The DNS indicated a lab request form from 9/25/16 noted a BMP was to be completed weekly and was done on 10/1/15, 10/8/15 and 10/22/15, but was not completed on 10/15/15 as ordered by a physician.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT 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 interview and record review, the facility failed to ensure one of three resident's (#66) reviewed for accidents, had adequate interventions to prevent a fall resulting in a fracture.</p> <p>Findings include:</p>	F 0323	<p>It is important to note that the Heritage of Fort Wayne had already identified this area of concern and had a Quality Improvement plan in place prior to the survey and this survey finding The Heritage of Fort Wayne's Quality Improvement plan for this finding was shared with the survey team when they</p>	04/01/2016

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	<p>An interview with LPN #1 on 3/10/16 at 1:53 P.M., indicated Resident #66 had a fall on 2/15/16 at the facility which resulted in a femur fracture.</p> <p>Review of Resident #66's record on 3/11/16 at 9:15 A.M. indicated the resident was admitted to the facility on 2/12/16 with diagnoses including, but not limited to, Alzheimer's disease, cognitive communication deficit, muscle weakness and a history of falling.</p> <p>On 2/12/16, a Morse Fall Scale Assessment was completed and indicated a score of 55, which is a high risk for falling. The instructions section indicated "Fall Risk is based upon Fall Risk Factors and is more than a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, quarterly, at change of condition, and after a fall. The assessment indicated the resident had: a history of falling; gait was normal/bedrest/wheelchair; ambulatory aid was none/bedrest/wheelchair/nurse assist; mental status was overestimates or forgets limits.</p> <p>Resident #66 had a Physician progress note, completed by a Nurse Practitioner (NP), from 2/15/16, at 10:30 A.M., which indicated Resident #66 had been sleeping</p>		<p>noted the concern with staff and there have not been other issues of this nature since implementation of the Quality Improvement plan put in place by Heritage of Fort Wayne A chart review has been completed for resident # 66 to ensure all areas of concern have been addressed and are up-to-date All residents admitted within the past month will be reviewed to ensure they have initial care plans for any areas of risk noted in their admission assessments Licensed nurses will be in-serviced regarding the implementation of initial care plans If admitted on Friday through Sunday the weekend supervisor will be responsible for monitoring for the initiation of admission care plans and any interventions needed</p> <p>(Attachment C) All new admissions will be reviewed weekly at morning IDT QA meetings to ensure all admission documentation is in place All concerns will be addressed at the quarterly QA meetings for further recommendations (Attachment D)</p>	

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	<p>when staff went into her room to check on her. Staff were in the next room when they heard yelling and ran back and found the resident on the floor. The left leg was shortened and externally rotate. The resident did not recall if she got dizzy, and couldn't tell much about the fall. Resident #66 was noted to have facial pain, swelling and redness over the left cheek. Complaints of leg, hip and knee pain. The resident was transported to a local Emergency Room for evaluation and treatment. The NP assessment indicated a left hip fracture.</p> <p>An interview with RN #2, on 3/11/16, at 10:11 A.M., indicated the resident was admitted to the facility on 2/12/16 which was a Friday, and the facility should have started an interim care plan upon admission. RN #2 did not believe an interim care plan was implemented before 2/15/16. RN #2 indicated fall interventions should have been added for Resident #66 based on being a high fall risk as indicated by the Morse Fall Assessment of 2/12/16.</p> <p>An interview with the Administrator (Admin), on 3/11/16, at 10:15 A.M. indicated Resident #66 did not have an interim care plan upon admission. The Admin indicated Resident #66 should have had an interim care plan upon</p>			

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	<p>admission on 2/12/16.</p> <p>An interview with the Director of Nursing Services (DNS) and the Admin was conducted on 3/11/16, at 10:38 A.M.. The DNS and Admin indicated the investigation of Resident #66's fall with a fractured femur on 2/15/16 occurred 30 seconds after a Certified Nursing Assistant (CNA) left the room. The CNA heard a noise and went back in the room and found the resident had fallen. The DNS and Admin indicated they believed Resident #66 had tried to transfer herself out of bed and fell. They indicated the resident was not to transfer herself and was to be assisted from bed to the wheelchair. The DNS and Admin indicated the resident was somewhat confused when she was admitted on 2/12/16 and indicated Resident #66 had been using the call light to call staff. The DNS and Admin indicated Resident #66 was readmitted from the hospital on 2/24/16 and an intervention of a bed alarm was added.</p> <p>On 3/14/16 at 1:59 P.M. an interview with Resident #66's spouse indicated the resident was not totally alert when she was admitted and had dementia, which was the reason for admission to a nursing home.</p>			

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F 0327 SS=D Bldg. 00	<p>On 3/14/16 at 2:03 P.M., the DNS provided a Fall Assessment Policy dated 2/15/16. The policy indicated all residents admitted to the facility were to be assessed upon admission to the facility for falls by nursing staff. The policy further indicated what actions were to be taken after a fall.</p> <p>On 3/14/16 at 2:03 P.M., the DNS provided a current undated policy for Resident Care Plans. Under General Guidelines: "An initial nursing care plan for the resident will be written and implemented upon admission.</p> <p>3.1-45(a)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview, the facility failed to monitor oral fluid intakes to ensure adequate fluids were consumed for 1 of 1 residents reviewed</p>	F 0327	Please note that there is not a regulation requiring the monitoring of fluid intakes Further, it is important to note that extra fluids were being offered to	04/01/2016

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	<p>for hydration, resulting in the resident requiring intravenous fluids (Resident #59).</p> <p>Findings include:</p> <p>The record for Resident #59 was reviewed on 3/14/2016 at 9:30 A.M. Diagnoses included, but were not limited to, metastatic malignant endometrial adenocarcinoma, intestinal obstruction, and hypertension.</p> <p>Physician orders for Resident #59 indicated the resident was prescribed Furosemide (medication used to treat hypertension and/or edema by eliminating excess fluid from the body) 40 milligrams once daily and potassium chloride 10 milliequivalents (potassium supplement) twice daily.</p> <p>An admission progress note by the facility Registered Dietitian (RD), dated 2/4/2016 at 1:37 P.M., indicated Resident #59's intakes were poor, with averages of 0-25% of meals consumed. The note also indicated the resident reported no issues with chewing or swallowing. The note further indicated Resident #59 was assessed as requiring 1380 cc (cubic centimeters) of fluids daily. The note indicated "(Resident's name) dx (diagnoses) of intestinal obstruction and</p>		<p>resident #59 and were often refused by the resident. The physician was indeed notified of the resident's low fluid intakes as indicated by an order for IV fluids. All residents with decreased intakes will be reviewed for possible signs and symptoms of dehydration. Any resident with signs/symptoms of dehydration will be seen by the dietician as well as the physician for recommendations. The family will also be notified of any findings/interventions for dehydration. Nutrition as Risk notes and Dietary recommendations by the consulting dietician will be reviewed weekly to identify other residents with the potential for dehydration. Dietician recommendations will be communicated with the physician for orders and other recommendations. Licensed nurses will be in-serviced on the signs/symptoms of dehydration and physician notification. (Attachment A) QA monitoring will be completed during morning IDT as well as weekly Nutrition at Risk meetings. All residents noted to be at risk for dehydration will be discussed and monitored for continued risk and/or resolutions of dehydration concerns will be addressed at the quarterly QA meetings for further recommendations. (Attachment B)</p>		

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	<p>poor intakes increase her risk for weight loss and dehydration."</p> <p>A "Nutritional Risk Assessment-Alternate" completed by the RD, dated 2/4/2016, indicated Resident #59 consumed less than 1000 cc of oral fluids daily.</p> <p>A care plan, dated 2/4/16, indicated Resident #59 was at risk for weight loss and dehydration related to dx of intestinal obstruction and poor intakes. The care plan indicated the goal for the resident as "Will maintain stable weight...and consume adequate fluids through next review date." Interventions on the care plan included, but were not limited to, "Encourage fluids unless otherwise specified" and "Monitor for s/sx (signs and symptoms) of dehydration."</p> <p>Fluid consumption intake records for Resident #59 for February 2016 were provided by the facility Director of Nursing Services (DNS) on 3/14/2016 at 1:30 P.M. The intake record indicated the resident had received 720 cc of fluid on 2/4/2016, 960 cc of fluid on 2/8/2016, and 300 cc of fluid on 2/13/2016. There was no other documentation of amount of fluids consumed on the resident's fluid intake record.</p>			

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	<p>A Medication Administration Record (MAR) for February 2016 indicated Resident #59 started receiving Boost (nutritional supplement) twice daily on February 11, 2016. The MAR indicated the resident consumed 240 cc of Boost on 2/11/2016, 287 cc on 2/12/2016, 480 cc on 2/13/2016, 237 cc on 2/14/2016, 287 cc on 2/15/2016, 100 cc on 2/16/2016, 471 cc on 2/17/2016, and 120 cc on 2/18/2016.</p> <p>A progress note by the physician, dated 2/18/2016 at 5:41 P.M., indicated "Pt (patient) with confusion. Appears to be coughing. Can't provide much history. Hx (history) is limited." The progress note indicated the plan was to obtain laboratory tests (complete blood count and comprehensive metabolic profile), a chest x-ray, a urinalysis, and to start intravenous fluids. The note further indicated "Based on labs and x ray results, further steps will be initiated." The note also indicated the resident's prognosis was guarded.</p> <p>A nursing progress note, dated 2/18/2016 at 6:24 P.M., indicated orders had been received from the physician to start intravenous fluids of normal saline (fluid used to treat dehydration).</p> <p>A physician progress note, dated</p>			

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	<p>2/19/2016 at 8:28 A.M., indicated Resident #59 was seen by the physician for a follow up visit. The note indicated the resident was still very weak. The note further indicated the resident's family had declined aggressive treatment in the past and the physician had been informed the resident's family was considering hospice. The note indicated the antihypertensive medications were to be held and the physician was waiting for the results of the comprehensive metabolic profile.</p> <p>A laboratory report, with a collection date of 2/19/2016 at 10:35 A.M. and reported date of 2/19/2016 at 11:23 A.M., indicated a blood urea nitrogen (an indicator of hydration status and kidney function) level of 79 mg/dL (milligrams per deciliter) with a normal reference range of 7-18 mg/dL and a Creatinine (an indicator of kidney function) level of 5.83 mg/dL with a normal reference range of 0.61-1.10 mg/dL. The report also indicated a potassium level of 9.0 mmol/L (millimole per liter, used in medicine to measure concentrations of substances in blood) with a normal reference range of 3.6 - 5.1 mmol/L.</p> <p>A nursing progress note, dated 2/19/2016 at 11:08 A.M., indicated the nurse had texted the nurse practitioner (NP) to</p>			

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	<p>advise her that the resident had pulled the IV.</p> <p>A progress note dated 2/19/2016 at 11:10 A.M. indicated the NP texted back to the nurse asking if the lab results were available.</p> <p>A progress note dated 2/19/2016 at 11:24 A.M. indicated the nurse texted back to the NP regarding the elevated potassium level.</p> <p>A note dated 2/19/2016 at 11:30 A.M. indicated the NP texted back to the requesting the nurse to call her as soon as possible.</p> <p>A nursing progress note, dated 2/19/2016 at 12:05 P.M., indicated the nurse called the NP with the results from the comprehensive metabolic profile and orders were received to continue the IV fluids. The note also indicated the resident was refusing to eat or drink and the family declined sending the resident to the hospital.</p> <p>The facility DNS was interviewed on 3/16/2016 at 10:00 A.M. During the interview, the DNS indicated the nursing staff had been routinely monitoring the resident for signs and symptoms of dehydration, but there was no further</p>			

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	<p>documentation to show fluid consumption for Resident #59. The DNS indicated meal consumption records only indicated the percentage of meals consumed, but did not indicate how much fluids the resident consumed at meals. The DNS indicated the facility staff did not routinely document the amount of fluids consumed by residents unless intakes were ordered to be monitored by the physician. The DNS also indicated Resident #59 had been resistant to consuming fluids.</p> <p>The facility RD was interviewed by telephone on 3/16/2016 at 10:40 A.M. During the interview, the RD indicated she had completed an admission assessment for Resident #59 on 2/4/2016 and had determined the resident required 1380 cc of fluids daily and she was consuming less than 1000 cc of fluids daily. The RD indicated because of medical conditions and poor oral intakes, Resident #59 was at risk for dehydration. The RD indicated the lab results obtained on 2/19/2016 for Resident #59 could indicate possible dehydration.</p> <p>CNA #5 was interviewed on 3/16/2016 at 11:20 A.M. During the interview, CNA #5 indicated Resident #59 had often refused fluids, except for coffee, but she would chew ice chips at times. CNA #5</p>			

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F 0329 SS=D Bldg. 00	<p>indicated fluid consumption could be documented by CNA's on their hand held electronic documentation devices. CNA #5 indicated the amount of fluids that were consumed could be documented, as well as a resident's refusal to consume fluids, on the devices.</p> <p>3.1-46(b)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that</p>			

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	<p>residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 5 residents (#47) reviewed for unnecessary medications, had adequate indications before starting an antipsychotic medication (Zyprexa).</p> <p>Findings include:</p> <p>Resident #47's record was reviewed on 3/14/16 at 2:00 P.M.. The record indicated the resident was most recently admitted to the facility on 8/18/15 and had diagnoses including, but not limited to, dementia, anxiety disorder, depressive disorder, . On 10/19/15 a physician's order was received to start Resident #47 on Zyprexa (an antipsychotic medication) 2.5 milligrams at bedtime for psychosis related to dementia.</p> <p>Review of a behavioral medicine evaluation and management note from 10/4/15 completed by the Nurse Practitioner (NP), indicated: "Patient continues as below, delirium due to low</p>	F 0329	<p>Please note that resident #47 has had a long term history of delusions and paranoia (per family) prior to entering Heritage of Fort Wayne The family has been and continues to be pleased with the progress resident #47 has made since being admitted to Heritage of Fort Wayne</p> <p>Resident #47 has had a medication regimen review by the consulting pharmacy to ensure #47 is free from unnecessary drugs In addition resident #47 had his/her medication in question discontinued All resident receiving antipsychotic drugs will have a drug regimen review to ensure they are free from unnecessary drugs</p> <p>Licensed nurses and social services will be in-serviced on antipsychotic medications All residents receiving antipsychotic medications will be monitored through Behavior Management program and GDR criteria (Attachment G) QA monitoring will be done monthly through review of all GDR's and review of adequate indications, including ruling out and the documentation</p>	04/01/2016

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NAME OF PROVIDER OR SUPPLIER HERITAGE OF FORT WAYNE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 5250 HERITAGE PARKWAY FORT WAYNE, IN 46835
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(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
	<p>sodium, explaining the hunger for salty foods, or dementia.</p> <p>Delirium: A. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention. B. A change in cognition or the development of a perceptual disturbance that is not better accounted for by a preexisting, established or evolving dementia. C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day. D. There is evidence from the history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition (low sodium)." The NP noted a diagnosis of delirium was added on 9/9/15. The NP indicated a conversation with Resident #47's physician in which the physician concurred that confusion may be due to low sodium. The NP indicated Resident #47's physician order fluid restrictions for low sodium.</p> <p>Review of physician's orders indicated Resident was on a fluid restriction of 1200 milliliters of fluid per day starting 10/4/15 and discontinued on 10/21/15.</p> <p>Review of lab results for basic metabolic profiles (BMP) which include sodium</p>		<p>of non-pharmacological interventions All findings will be reviewed at the quarterly QA committee meeting for recommendations (Attachment H)</p>	

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	<p>levels were completed and indicated sodium levels of: 9/19/15: 127 (normal 134-146); 9/20/15- 127; 9/21/15- 125; 9/22/15- 121; 10/1/15- 130; 10/8/15- 129; 10/22/15-139. The BMP labs completed through March 2016 have continued to have sodium levels in the normal range, between 134-146.</p> <p>A progress note of 10/26/15 at 4:30 P.M. indicated Resident #47 was seen by a nephrologist due to follow up due to low sodium. The resident's family member, who was present for the appointment stated the MD wasn't aware of the reason for the visit as the test he needed to perform needed to be done while the resident's sodium is low and the sodium was normal at that time.</p> <p>An interview with the Social Service Director (SSD) on 3/14/16 at 2:41P.M. indicated Resident #47 had severe paranoia, delusions, and crying noted before starting Zyprexa on 10/20/15. The SSD indicated the Resident #47's behavior has improved and is no longer paranoid.</p> <p>Review of a current policy titled Antipsychotic Medications in Resident's with Dementia, from 6/2013, was provided by the Administrator. Under policy, "An antipsychotic trial is</p>			

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F 0520 SS=C Bldg. 00	<p>warranted only when non-pharmacological intervention is unsuccessful; and neuropsychiatric symptoms or associated behaviors cause severe distress or pose a significant safety risk to self or others. Under the section "Cause Identification and Diagnosis", 1. "Staff and the practitioner will identify possible risk and contributing factors for behaviors such as: the presence of co-existing medical or psychiatric conditions. I.e. pain, constipation, delirium, decreased cognition, infection, depression, etc."</p> <p>3.1-48(b)(1)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require</p>			

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	<p>disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview the facility failed to ensure the Medical Director attended Quality Assessment and Assurance meetings.</p> <p>Findings include:</p> <p>An interview with the Administrator on 3/16/16 at 2:05 P.M. indicated the Quality Assessment and Assurance Committee consisted of the Medical Director, the Administrator, Director of Nursing, Social Services Director, Wound/Inservice Nurse, Business Office Manager, Dietary Manager, Environmental Services Manager, Director of Maintenance, Activities Director, and the MDS Nurse.</p> <p>The Administrator indicated the Medical Director does not attend the Quality Assessment and Assurance meetings.</p> <p>3.1-52(a)(2)</p>	F 0520	<p>Please note that the administrator was asked by a surveyor if a physician physically attended the QA committee meetings The regulation for tag F520 does not indicate that the physician's physical attendance at the Quarterly Quality Assurance meeting is required The regulation does require a physician to be on the QA committee Heritage of Fort Wayne does have their medical director serve on the committee reviewing reports, notes, and giving recommendations The medical director will attend the next quarterly quality assurance meeting which is scheduled for April 12, 2016 at 5pm All residents at Heritage of Fort Wayne are affected by the quality assurance program and subsequent findings and improvements A calendar for the quality assurance committee meetings has been developed and reviewed along with the F520 tag with the medical director and other QA committee members (Attachment I) All quarterly quality assurance committee meetings will be monitored quarterly for attendance by all</p>	04/01/2016

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R 0000 Bldg. 00	The Heritage of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.	R 0000	required committee members (Attachment I)		