

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
--	--

(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	<p>This visit was for the Investigation of Complaint IN00151301.</p> <p>Complaint IN00151301 Substantiated. Deficiencies related to the allegations are cited at F 309 and F 514.</p> <p>Survey date: June 23, 2014</p> <p>Facility number : 000275 Provider number: 155656 AIM number: 100290930</p> <p>Survey team: Christine Fodrea, RN</p> <p>Census bed type: SNF: 19 SNF/NF: 100 Total: 119</p> <p>Census payor type: Medicare: 19 Medicaid: 78 Other: 22 Total: 119</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for the statement of deficiencies. The plan of correction is prepared and/or solely executed because it is required by the provisions of federal and state law. The facility respectfully request that this plan of correction be considered for a desk review since tags cited were as isolated deficiency with no actual harm.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
--	--

(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
F000309 SS=D	<p>Quality Review completed on June 25, 2014 by Randy Fry RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to adequately assess pain for 2 of 3 residents reviewed with pain in a sample of 3. ( Resident #N and Resident #O)</p> <p>Findings include:</p> <p>1. Resident #N's clinical record was reviewed on 6-23-2014 at 11:24 AM. Resident #N's diagnoses included, but were not limited to, high blood pressure, joint pain, and kidney failure.</p> <p>Resident #N's Medication Administration Record (MAR) dated 6-2014 indicated Resident #N received Tramadol (a pain medication) 50 Milligrams (mg) at 4:30 AM on 6-6-2014. There was no</p>	F000309	<p>F 309</p> <p>It is the policy of the facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. Corrective action for alleged deficient practice:</p> <p>1. Resident #N no longer resides in facility. Resident #O has received a pain assessment, has PRN Analgesic Record/Pain Flow Sheet in progress, and is receiving medications as ordered.</p> <p>Identification of others with potential to be affected by alleged deficient practice:</p> <p>1. Residents receiving PRN pain medications are at risk. 100% audit to be completed on residents receiving PRN medications by ensuring pain assessment, PRN</p>	07/09/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
--	--

(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>indication on the MAR the pain had been assessed.</p> <p>Nurse's notes dated 6-6-2014 at 12:00 AM, indicated Resident #N had no complaints of pain and was resting easily. There was no further note for 6-6-2014, and no note regarding the level of pain or location.</p> <p>In an interview on 6-23-2014 at 3:01 PM, RN #1 indicated an assessment would have been documented on the MAR or in the Nurse's notes if it had been completed.</p> <p>2. Resident #O's clinical record was reviewed on 6-23-2014 at 1:58 PM. Resident #O's diagnoses included, but were not limited to, diabetes, dementia, and high blood pressure.</p> <p>Resident #O's MAR dated 6-2014 indicated Resident #O had been given Tylenol 325 mg at 11:40 AM on 6-17-2014, on 6-21-2014 at 12 AM, and 6-22-2014 at 2 AM. There was no indication on the MAR the level or location of the pain for any of these entries had been assessed.</p> <p>Nurse's notes dated 6-17-2014 at 8 PM indicated Resident #O had no complaints of pain, and there was no mention of an</p>		<p>Analgesic Record/Pain Flow Sheet is in use, and residents are receiving medications per order.</p> <p>Systematic changes in place for alleged deficient practice:</p> <ol style="list-style-type: none"> <li>Licensed nurses will be re-educated on policy regarding pain management. PRN Analgesic Record/Pain Flow Sheets will be added to admit packs and placed on Admission Process Checklist for initiation upon admission.</li> </ol> <p>How corrective action will be monitored to ensure alleged deficient practice does not reoccur:</p> <p>1: Nurse managers will audit MARS (medication administration record), PRN Analgesic Record/Pain Flow Sheet five times weekly x 2 weeks, 3x weekly x 2 weeks, weekly x 1 month, then monthly thereafter to ensure evaluation and documented effectiveness of pain management interventions on the Medication Administration Record. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine further education and/ or further monitoring needs. Identified non-compliance will result in one to one re-education up to and/or termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/23/2014
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835		
(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	
F000514 SS=D	<p>earlier pain assessment.</p> <p>Nurse's notes dated 6-21-2014 at 1 PM indicated Resident #O had no complaints of pain, but did not indicate an assessment of her earlier pain had been completed.</p> <p>Nurse's notes dated 6-22-2014 at 2 AM indicated Resident #O had no signs or symptoms of pain. There was no indication an assessment of Resident #O's pain had been completed.</p> <p>In an interview on 6-23-2014 at 1:19 PM, RN #2 indicated pain was to be assessed using the 1-10 number system with each complaint of pain. RN #2 further indicated the location of the pain should be assessed as well.</p> <p>This Federal tag relates to Complaint IN00151301.</p> <p>3.1-37(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
--	--

(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>professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to accurately document observations and care given by CNAs for 1 of 3 residents reviewed for CNA observations and care. (Resident #N) The facility further failed to accurately document reasons for medications not given for 2 of 3 residents reviewed for medications not given in a sample of 3. (Resident #N and Resident #O)</p> <p>Findings include:</p> <p>1. Resident #N's record was reviewed on 6-23-2014 at 11:24 AM. Resident #N's diagnoses included, but were not limited to, high blood pressure, joint pain, and kidney failure.</p> <p>In an interview on 6-23-2014 at 3:01 PM, RN #1 indicated when the third shift came on duty on 6-5-2014, RN #1, RN #3 and the third shift CNA went into Resident #N's room to meet her and do a</p>	F000514	<p>It is the policy of this facility to accurately document observations and care.</p> <p>be forwarded to the administrator for review and presented to QA to determine further Corrective action for alleged deficient practice:</p> <p>1. Resident #N no longer resides in facility. Resident #O has had a review of MARs (Medication Administration Record) to ensure resident is receiving medications as ordered.</p> <p>Identification of others with potential to be affected by alleged deficient practice:</p> <p>1. Residents receiving medications are at risk. 100% audit to be completed on residents MARs (Medication Administration Records) to ensure residents are receiving medications per order. 100% audit to be completed to ensure residents have appropriate care tracker documentation in place.</p> <p>Systematic changes in place for alleged deficient practice:</p>	07/09/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/23/2014
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835		
(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>face to face report as the resident had just been admitted to the facility.</p> <p>In an interview on 6-23-2014 at 1:54 PM, RN #3 indicated she had checked on Resident #O frequently throughout the night. She further indicated Resident #O had slept well, and she had given Resident #O a pain pill about 4:30 AM. RN #3 also indicated she could not say the type of care Resident #O received from the CNA, but it would be documented on the care tracker.</p> <p>A review of Resident #O's care tracker indicated there was no documentation on 6-5-2014. The review further indicated the care tracker had not been activated until 6-6-2014 at 8 AM.</p> <p>In an interview on 6-23-2014 at 1:24 PM, the Director of Nursing (DON) indicated the care tracker should have been activated immediately after the resident's admission to the facility.</p> <p>2. Resident #N's Medication Administration Record (MAR) dated 6-2014 indicated Resident #N's Calcium Lactate (a dietary supplement) 650 mg (milligrams) had been circled on 6-6-2014 for the 4 AM, 8 AM, 1 PM, and 6 PM doses. There was no documentation concerning the Calcium Lactate on the</p>		<p>1. Licensed nurses will be re-educated on medication documentation policy. Licensed nurses will be re-educated on process of initiation of care tracker documentation for new admissions. Care tracker activation will be placed on Admission Process Checklist for initiation upon admission and verified as part of post-admission checklist.</p> <p>How corrective action will be monitored to ensure alleged deficient practice does not reoccur:</p> <p>1. Nurse managers will print Caretracker reports for active resident census to ensure appropriate care tracker documentation. Nurse Managers will audit MARs (Medication Administration Record) five times weekly x 14 days, then weekly x 8 weeks, then random reviews monthly x 6 months to ensure medication administration and documentation is completed. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine further education and/ or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will educational needs.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/23/2014	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(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>back of the MAR.</p> <p>In an interview on 6-23-2014 3:01 PM, RN #1 stated circling an initial on the MAR indicated the medication had not been given. Additionally, RN #1 stated the reason for the medication not being given should have been noted on the back of the MAR or in the Nurse's notes.</p> <p>A review of Nurses notes dated 6-6-2014 indicated the only entry for the day was timed at 12 AM. There was no indication why the Calcium Lactate had not been given.</p> <p>3. Resident #O's record was reviewed 6-23-2014 at 1:58 PM. Resident #O's diagnoses included, but were not limited to, diabetes, dementia, and high blood pressure.</p> <p>Resident #O's MAR dated 6-2014 indicated Resident #O 's Alendronate (an osteoporosis treatment medication) 70 mg had been circled on 6-19-2014. The medication was ordered to be given weekly and a square had been placed on 6-25-2014, to indicate the medication should be given then. Additionally, there were initials on the 6-20-2014 space to indicate the medication had been given on 6-20. There were no initials in the box dated 6-18-2014. There was no</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
--	--

(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>documentation on the back of the MAR to indicate why the medication had not been given on 6-18 or 6-19-2014.</p> <p>A review of Nurse's notes dated 6-18, and 6-19-2014 did not indicate why the Alendronate had not been given.</p> <p>This Federal tag relates to Complaint IN00151301.</p> <p>3.1-50(a)(1)</p>			