

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 18, 19, 20, 21, & 24, 2014</p> <p>Facility number: 000038 Provider number: 155095 AIM number: 100274830</p> <p>Survey team: Sue Brooker RD TC Martha Saull RN Julie Call RN Virginia Terveer RN</p> <p>Census bed type: SNF: 20 SNF/NF: 141 Total: 161</p> <p>Census payor type: Medicare: 25 Medicaid: 102 Other: 34 Total: 161</p> <p>These deficiencies reflect state findings cite in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 26, 2014 by Randy Fry RN.</p>	F000000	<p>Heritage Park respectfully requests a face-to-face IDR due to disagreeing with severity of F-325Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers or directors. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper</p>	

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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F000157 SS=D	<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</p>		compliance review in lieu of a Post Survey Review on or after March 14, 2014.		

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	<p>the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of Resident #82 when she experienced a severe weight loss.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #82 on 2/24/14 at 2:37 p.m., indicated the following: diagnoses included, but were not limited to, depressive disorder, anxiety state, Alzheimer's disease, esophageal reflux, and nonorganic psychosis.</p> <p>A physician's order for Resident #82, dated 5/2/13, indicated she received a Regular Diet.</p> <p>A physician's order for Resident #82, dated 8/15/13, indicated to decrease Remeron from 30 mg (milligrams) HS (hour of sleep) to 15 mg HS. The original order for 30 mg Remeron was dated 9/1/10.</p> <p>A Nutrition Risk Assessment for Resident #82, dated 11/24/13 and completed by the Registered Dietitian (RD), indicated she received a Regular Diet with ice cream at dinner. The</p>	F000157	<p>F-157It is the practice of this provider to ensure the physician is notified when a resident exhibits a significant weight loss. However, based on the alleged deficient practice the following has been implemented:What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #82The physician has been notified of the significant weight loss.No other residents were identified to have been affected by the alleged deficient practice.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:Residents presenting with a weight loss have the potential to be affected by the alleged deficient practice.The facility Registered Dietician reviewed weight loss logs and no other residents were identified to have been affected by the alleged deficient practice.The facility Nutrition At Risk Interdisciplinary Team has been re-educated on physician notification regarding significant weight loss. Education includes but is not limited to reviewing weight logs weekly to identify concerns and notifying the physician of significant weight loss findingsThe Unit Manager will initiate physician notification</p>	03/14/2014

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	<p>assessment also indicated her current weight was 117 pounds with a usual body weight range of 114-119 pounds. The assessment further indicated she had a BMI (Body Mass Index) of 17, which placed her weight status as underweight and her overall nutritional risk was high. The assessment indicated Remeron was prescribed as an appetite stimulant.</p> <p>A Nutrition Progress Note for Resident #82, dated 11/24/13 and written by the RD, indicated a weight of 117 pounds with a BMI of 17 (below recommended guidelines). The note also indicated she remained on a Regular Diet with ice cream at dinner and an overall intake of 50%. The note further indicated she received Remeron as an appetite stimulant. No recommendations were made.</p> <p>A facility Vitals Report for Resident #82 indicated the following weights: 117 pounds on 11/7/13, 116 pounds on 12/4/13, 111 pounds on 1/3/14, 111 pounds on 1/24/14, 109 pounds on 1/31/14, 109 pounds on 2/5/14, and 105 pounds on 2/14/14.</p> <p>Based on facility weights, Resident #82's weight had decreased 8 pounds from 11/7/13 to 1/31/14, or 6.8%, indicating a severe weight loss and had decreased 14</p>		<p>when the Registered Dietician identifies significant weight loss has occurred and will document this communication in the IDT not of the medical record. The Registered Dietician is responsible for compliance. The RD/Designee reviews the Interdisciplinary Team notes for residents identified as significant weight loss to ensure physician notification is documented. Education provided by the DNS on March 6, 2014. What changes will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: The facility Nutrition At Risk Interdisciplinary Team has been re-educated on the physician notification regarding significant weight loss. Education includes but is not limited to reviewing weight logs weekly to identify concerns and notifying the physician of significant weight loss findings. The Unit Manager will initiate physician notification when the Registered Dietician identifies significant weight loss has occurred and will document this communication in the IDT note of the medical record. The Registered Dietician is responsible for compliance. The RD/Designee will review the Interdisciplinary Team notes for residents identified as significant weight loss to ensure physician notification is documented. Education provided</p>	

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	<p>pounds from 8/1/13 to 2/14/14, or 11.76%, indicating a severe weight loss.</p> <p>There were no additional Dietary or Nutrition Progress Notes or Nutrition Risk Assessment for Resident #82 since 11/24/13 available in the clinical record addressing her weight loss.</p> <p>There was no evidence in the clinical record for Resident #82 her physician had been notified of her severe weight loss.</p> <p>A facility care plan for Resident #82, with a start date of 11/13/13, indicated the problem area of potential for altered nutritional status due to varied food and fluid intake. The goal to the problem was the resident would tolerate current diet with no significant weight changes. Approaches to the problem included, but were not limited to, Regular Diet, snacks available between meals, provide Remeron as ordered, monitor food/fluid intake at meals, monitor weight, notify MD/family of significant weight changes, and offer substitute if <75% of any meal was consumed.</p> <p>The RD was interviewed on 2/24/14 at 4:22 p.m. During the interview she indicated facility weights were recorded and given to her by 7th day of the month. She also indicated she then put the</p>		<p>by the DNS March 6, 2014. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A CQI monitoring tool titled "Weight Loss" will be utilized every week x 4, monthly x 6 and quarterly thereafter Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will be developed Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

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	<p>weight into the computer to determine any trends in weight loss. She further indicated she had noticed a trending weight loss for Resident #82.</p> <p>The RD was interviewed on 2/24/14 at 4:47 p.m. During the interview she indicated Resident #82 had been missed and not added to the NAR (Nutrition at Risk) program. She also indicated no additional dietary interventions had been started for Resident #82 after her severe weight loss.</p> <p>A current facility policy "Resident Weight Monitoring", revised on April, 2011, and provided by the Certified Dietary Manager on 2/24/14 at 3:53 p.m., indicated "...Upon obtaining monthly weights and entering them onto the log, a monthly weight change report is distributed by the 7th day of the month to the following individuals: a. Director of Nursing Services b. Registered Dietitian c. Dietary Services Manager/Dietary Clinician d. MDS Coordinator...The Dietary Services Manager/Dietary Clinician and Director of Nursing Services (or designee) review the resident weight log no less than monthly. The Interdisciplinary Team (IDT) will be alerted to residents who have weight and/or nutritional concerns...Residents who have experienced</p>			

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	<p>significant...weight loss...will be brought to the attention of the Interdisciplinary Team. The team reviews possible medical, physical, social, or psychological reasons for the weight loss...and develops a care plan to reverse the condition...Any unexplained weight loss is considered a change in condition...Possible involvement from the various discipline's include:...Physician: Medical intervention for conditions or diagnosis of conditions that may contribute to weight variance...."</p> <p>A current facility policy "NAR Expectations", revised on September, 2013, and provided by the Registered Dietitian on 2/24/14 at 4:48 p.m., indicated "...Residents who trigger for significant weight loss (30, 90, or 180d) will be placed on weekly weight and an initial IDT note will be written...If weekly weights show a loss, the resident's nutritional status is reviewed and an IDT note will be written...Each note will include confirmation of MD/Family notification and any response to this...."</p> <p>3.1-5(a)(2)</p>				

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.			

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	<p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to reassess the effectiveness of recommended Level II PASRR (Preadmission Screening and Resident Review) services for 1 of 1 resident's reviewed for PASRR services. Resident #32</p> <p>Findings include:</p> <p>On 2/20/14 at 10 A.M., the clinical record of Resident #32 was reviewed. Diagnoses included, but were not limited to, the following: Schizoaffective disorder, depression and anxiety.</p> <p>On 2/21/14 at 10:08 A.M., the Social Service Staff (SSS) provided the following documentation: Certification of PASRR/MI (mental illness), Preadmission Screening Determination. This form included, but was not limited to, the following: "...Level II certification</p>	F000280	<p>F-280It is the practice of this provider to ensure reassessment of the effectiveness of recommended Level II PASRR services. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #32A careplan has been formulated indicating this provider will request an annual review for Level II resident review. During annual survey, the facility notified the agency responsible for completing the annual reviews of a potential missed Level II. The agency responded that the referral was inappropriate as this resident did not need to be reviewed annually. The agency confirmed they were aware of this resident and services she receives. Per their documents; she is stable on current treatment plan and will only be reviewed if there is a</p>	03/14/2014

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	<p>date 2/3/11...Level II Mental Health Determination...the Applicant/Resident is mentally ill...and does not require specialized services...The applicant/resident meets the criteria for facility admission...Level II finds a diagnosis of Schizoaffective disorder, depressive disorder, dementia of Alzheimer's type...services of less intensity than specialized services...continue current MH (mental health) services, yearly resident review..."</p> <p>At the time, the SSS was interviewed. She indicated the resident had been admitted to the facility in February 2011. She indicated the only documented level II PASRR screening had a signature date of 1/31/11. She indicated this form had documented the resident was to have a yearly resident review and documentation was lacking in the clinical record of a yearly resident review having been done since the initial screening on 1/31/11. The SSS indicated the (name of agency to perform yearly resident review) had determined the resident was an "inappropriate referral" due to the resident having regularly seen a psychiatrist. The SSS indicated the resident goes out of the building to see (name of psychiatrist).</p> <p>On 2/21/14 at 11:30 A.M., the SSS</p>		<p>significant change. In addition; this resident was reviewed as part of the periodic minimum data set (MDS) audit which is completed for all Indiana Health Coverage programs in June of 2012. Her original Level II was dated 2/2011 and had the auditors found a need for a Level II resident review they would have made the referral at that time for 2012. This resident has been consistently followed by an outside provider of mental health services since admission she is seen quarterly and her actual care plan is reviewed quarterly. These interventions far exceed the requirement for annual review. While the facility does not have a specific policy to state how PASARR recommendations are monitored, we do have a care plan policy which clearly indicates that the aspects of the residents treatment plan are to be reviewed quarterly, annually and with a significant change including any mental health services received or needed. No other residents were identified to have been affected by the alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents meeting the criteria for an annual resident review have the potential to be affected by the alleged deficient practice. Social Services</p>				

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	<p>indicated the facility did not have a policy and procedure regarding how PASRR residents were monitored to ensure recommendations were followed.</p> <p>On 2/21/14 at 3:22 P.M., copies of the resident's current care plans were reviewed. A plan of care for "Behavior:...diagnosis of Schizoaffective disorder and utilizes antipsychotic medications...Approach...psych (psychiatric) services prn (as needed)..." The "Problem Start Date" was 12/6/11.</p> <p>On 2/24/14 at 1:30 P.M., the DON (Director of Nursing) was interviewed. At the time, she reviewed the resident's current care plans. She indicated documentation was lacking in the clinical record of a current plan of care to address a Level II PASRR status and/or review.</p> <p>3.1-35(d)(2)(B)</p>		<p>conducted an audit of facility Level II residents. No other residents were identified as being affected by the alleged deficient practice. A Tracking Tool is utilized to ensure residents requiring a Level II are identified and a request is submitted for a Resident Annual Review annually. New admissions to the facility are reviewed routinely in the next scheduled morning Interdisciplinary Team Meeting. A careplan is developed reflecting the facility will request a Level II resident review annually. Level II documentation is reviewed in the meeting and subsequently uploaded into the computerized Matrix medical record. Resident documentation for Level IIs are reviewed at scheduled care plan meetings quarterly, annually and with significant changes to ensure compliance. Social Services has been re-educated on appropriate updating of Level II requirements. Education includes but is not limited to identifying which annual residents require annual reviews, how to notify outside agencies of significant changes and ensuring recommendations are met. Education was provided by the Executive Director on March 11, 2014. Social Services Director is responsible for compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: New admissions to the</p>		

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			<p>facility are reviewed routinely in the next scheduled morning Interdisciplinary Team Meeting. Level II documentation is reviewed in the meeting and subsequently uploaded into the computerized Matrix medical record including the care plan. Resident documentation for Level IIs are reviewed at scheduled care plan meetings quarterly, annually and with significant changes to ensure compliance. Social Services has been re-educated on appropriate updating of Level II requirements. Education includes but is not limited to identifying which annual residents require annual reviews, how to notify outside agencies of significant changes and ensuring recommendations are met. Education was provided by the Executive Director on March 11, 2014. Social Services Director is responsible for compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A CQI monitoring tool titled "Level II Compliance" will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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 interview and record review, the facility failed to ensure a Level II PASRR (Preadmission Screening and Resident Review) annual review was completed for 1 of 1 resident's reviewed for PASRR services.</p> <p>Resident #32. Based on observation, interview and record review the facility further failed to follow physician orders for a fluid restriction for 1 resident (Resident #38) of 1 resident reviewed for dialysis.</p> <p>Findings include:</p> <p>1. On 2/20/14 at 10 A.M., the clinical record of Resident #32 was reviewed. Diagnoses included, but were not limited to, the following: Schizoaffective disorder, depression and anxiety.</p> <p>On 2/21/14 at 9:48 A.M., the SSS (Social Service Staff) was interviewed. She indicated she had not yet received the resident's annual evaluation from (the name of the facility which performs the</p>	F000282	F-282 It is the practice of this provider to ensure Level II PASRR annual reviews are completed and physician orders for fluid restrictions are followed. However, based on the alleged deficient practice of following has been implemented: Resident #32 During annual survey, the facility notified the agency responsible for completing the annual reviews of a potential missed Level II. The agency responded that the referral was inappropriate as this resident did not need to be reviewed annually. The agency confirmed they were aware of this resident and services she receives. Per their documents; she is stable on current treatment plan and will only be reviewed if there is a significant change. In addition; this resident was reviewed as part of the periodic minimum data set (MDS) audit which is completed for all Indiana Health Coverage programs in June of 2012. Her original Level II was dated 2/2011 and had the auditors found a need for a Level II resident review they would have made the referral at that time for 2012. This resident has been consistently followed by an outside provider of mental health	03/14/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>annual Level II evaluations) for 2013. The SSS indicated the most recent Level 2 evaluation the facility had for the resident was February 2011.</p> <p>On 2/21/14 at 10:08 A.M., the Social Service Staff (SSS) provided the following documentation: Certification of PASRR/MI (mental illness), Preadmission Screening Determination. This form included, but was not limited to, the following: "...Level II certification date 2/3/11...Level II Mental Health Determination...the Applicant/Resident is mentally ill...and does not require specialized services...The applicant/resident meets the criteria for facility admission...Level II finds a diagnosis of Schizoaffective disorder, depressive disorder, dementia of Alzheimer's type...services of less intensity than specialized services...continue current MH (mental health) services, yearly resident review..."</p> <p>At the time, the SSS was interviewed. She indicated the resident had been admitted to the facility in February 2011. She indicated the only documented level II PASRR screening had a signature date of 1/31/11. She indicated this form had documented the resident was to have a yearly resident review. She indicated she had put in a request (to name of agency to</p>		<p>services since admission she is seen quarterly and her actual care plan is reviewed quarterly. These interventions far exceed the requirement for annual review. While the facility does not have a specific policy to state how PASARR recommendations are monitored, we do have a care plan policy which clearly indicates that the aspects of the residents treatment plan are to be reviewed quarterly, annually and with a significant change including any mental health services received or needed. No other residents were identified to have been affected by the alleged deficient practice. Resident #38 Education was immediately provided to Resident and Responsible Party of possible negative effect of continued fluid restriction non-compliance. The fluid restriction was discontinued by the physician due to the Resident and Responsible Party's desire to keep liquids at bedside and their desire to allow the Resident to choose what and how much to drink at meals. This provider continues to honor Resident's choice to consume fluids as desired. No other resident were identified to have been affected by the alleged deficient practice How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents requiring a Level II and Residents</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>perform the evaluations) for an annual evaluation on 11/15/13 but hadn't heard back yet regarding her request. She indicated documentation was lacking in the clinical record of a yearly resident review having been done since the initial screening on 1/31/11. The SSS indicated at the time, (name of agency to perform yearly resident review) was currently putting information into the State site that the resident doesn't need a yearly review because the resident currently saw (name of psychiatrist). The SSS indicated the (name of agency to perform yearly resident review) had determined the resident was an "inappropriate referral" due to the resident having regularly seen a psychiatrist. The SSS indicated the resident goes out of the building to see (name of psychiatrist).</p> <p>On 2/21/14 at 11:30 A.M., the SSS indicated the facility did not have a policy and procedure regarding how PASRR residents are monitored to ensure recommendations are followed.</p> <p>On 2/21/14 at 3:22 P.M., copies of the resident's current care plans were reviewed. A plan of care for "Behavior:...diagnosis of Schizoaffective disorder and utilizes antipsychotic medications...Approach...psych (psychiatric) services prn (as needed)..."</p>		<p>with a physicians order for fluid restrictions have the potential to be affected by the alleged deficient practice. DNS/Designee has conducted an audit to ensure physicians orders are followed for fluid restrictions. Nursing staff have been re-educated on required documentation for Residents with a physician ordered fluid restriction. Education includes but is not limited to documentation requirements for calculating meal fluids, medication pass fluids and supplement fluids accurately and reflecting accurate daily totals on the Resident Consumption Log in Matrix and Fluid Restriction Log in EMAR Education provided by the DNS and Clinical Education Co-ordinator completed on March 10, 2014. Social Services has been re-educated on the Level II compliance process. Education includes but is not limited to identifying when a Level II is required and reviewing PASRR services annually. Education provided by the Executive Director March 10, 2014. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Nursing staff have been re-educated on required documentation for Resident's with a physician ordered Fluid Restriction. Education includes but is not limited to documentation requirements for calculating meal</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805			
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	<p>On 2/24/14 at 11:31 A.M., the Administrator (ADM) was interviewed. She indicated the facility was unable to locate documentation from the (name of Medicaid audit which indicated if the Level 2 PASRR is inappropriate or not), which she indicated was done in July 2012. The ADM indicated based on the State Agency request for documentation of an annual evaluation from 2012, (name of the facility who performed the Level 2 assessments) indicated the resident was "an inappropriate Level 2 due to her nursing needs taking precedence over her mental health needs." The ADM indicated documentation was lacking of an annual assessment for a Level 2 having been completed in 2012 and/or 2013.</p> <p>2. Review of the clinical record for Resident #38 on 2/20/14 at 9:56 a.m., indicated the following: diagnoses included, but were not limited to, CHF (congestive heart failure), chronic kidney disease Stage III, and diabetes mellitus.</p> <p>A physician's order for Resident #38, dated 1/29/14, indicated a Consistent Carbohydrate No Added Salt diet with double meat. The order also indicated a fluid restriction of 1500 cc's (cubic centimeters) - 240 ml (milliliter) with</p>		<p>fluids, med pass fluids and supplement fluids accurately and reflecting accurate totals on the Resident Consumption Log maintained on the paper log. The DNS/Designee will review charge nurse documentation to ensure physician orders are followed for fluid intake. Education provided by the DNS and Clinical Education Co-ordinator completed March 10, 2014. The RN Unit Managers are responsible for compliance. Social Services has been re-educated on the Level II compliance process. Education includes but is not limited to identifying when a Level II is required and reviewing PASRR services annually. New admissions to the facility are reviewed routinely in the next scheduled morning Interdisciplinary Team Meeting. Level II documentation is reviewed in the meeting and subsequently uploaded into the computerized Matrix medical record including the care plan. Resident documentation for Level IIs are reviewed at scheduled care plan meetings quarterly, annually and with significant changes to ensure compliance. Social Services has been re-educated on appropriate updating of Level II requirements. Education includes but is not limited to identifying which annual residents require annual reviews, how to notify outside agencies of</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>meals, 300 ml on 1st shift, 300 ml on 2nd shift, and 180 ml on 3rd shift.</p> <p>A physician's order for Resident #38, with a start date of 2/3/14, indicated Nepro, 1 can with AM med pass.</p> <p>A Nutrition Risk Assessment for Resident #38, dated 2/17/14, indicated she received a Consistent Carbohydrate No Added Salt diet with double meat, 240 cc's of Nepro daily, and a fluid restriction of 1500 cc's per day.</p> <p>A MatrixCare Report as part of the Medication Administration Record for Resident #38, indicated she received the following fluid amounts with meals and between meals: 1169 cc's on 2/1/14, 973 cc's on 2/2/14, 1140 cc's on 2/3/14, 1020 cc's on 2/4/14, 1020 cc's on 2/5/14, 1200 cc's on 2/6/14, 840 cc's on 2/7/14, 746 cc's on 2/8/14, 1080 cc's on 2/9/14, 1200 cc's on 2/10/14, 1200 cc's on 2/11/14, 1200 cc's on 2/12/14, 1200 cc's on 2/13/14, 900 cc's on 2/14/14, 720 cc's on 2/15/14, 960 cc's on 2/16/14, 1200 cc's on 2/17/14, 1200 cc's on 2/18/14, and 1080 cc's on 2/19/14.</p> <p>A MatrixCare Report, completed on the kiosk in the resident hallway, for Resident # 38, indicated she received the following fluid amounts: 480 cc's on</p>		<p>significant changes and ensuring recommendations are met. Education provided by the Executive Director March 10, 2014. The Social Services Director is responsible for compliance How the corrective action(s) will be monitored to ensure the deficient practice will not recur: CQI monitoring tools titled "Fluid Restriction" and "PASRR Level II" will be utilized every week x 4, monthly x 6 and quarterly thereafter Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will e developed Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>2/1/14, 960 cc's on 2/2/14, 720 cc's on 2/3/14, 960 cc's on 2/4/14, 600 cc's on 2/5/14, 480 cc's on 2/6/14; 720 cc's on 2/7/14, 240 cc's on 2/8/14, 720 cc's on 2/9/14, 600 cc's on 2/10/14, 600 cc's on 2/11/14, 360 cc's on 2/12/14, 480 cc's on 2/13/14, 480 cc's on 2/14/14, 480 cc's on 2/15/14, 480 cc's on 2/16/14, 720 cc's on 2/17/14, 600 cc's on 2/18/14, and 720 cc's on 2/19/14.</p> <p>The MatrixCare Report in the Medication Administration Record and the MatrixCare Report completed on the kiosk in the resident hallway for Resident #38, indicated she received the following fluid amounts: 1649 cc's on 2/1/14, 1933 cc's on 2/2/14, 1860 cc's on 2/3/14, 1980 cc's on 2/4/14, 1620 cc's on 2/5/14, 1680 cc's on 2/6/14, 1560 cc's on 2/7/14, 986 cc's on 2/8/14, 1800 cc's on 2/9/14, 1800 cc's on 2/10/14, 1800 cc's on 2/11/14, 1560 cc's on 2/12/14, 1680 cc's on 2/13/14, 1380 cc's on 2/14/14, 1200 cc's on 2/15/14, 1440 cc's on 2/16/14, 1920 cc's on 2/17/14, 1800 cc's on 2/18/14, and 1800 cc's on 2/19/14. On 15 of the 19 days reviewed, Resident #38 received more than the 1500 cc's per day as ordered for her fluid restriction.</p> <p>A facility care plan for Resident #38, with a start date of 9/19/13, indicated the problem area of resident requires a</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>therapeutic diet related to dialysis.</p> <p>Approaches to the problem included, but were not limited to, resident at times noncompliant with fluid restriction, 240 cc's Nepro daily to be included within 1st shift med pass, 1500 cc fluid restriction: 240 cc's with meals, 300 cc's on 1st shift, 300 cc's on 2nd shift, and 180 cc's on 3rd shift, ice cream with lunch, and monitor food/fluid intake at meals.</p> <p>During an observation of the lunch meal on 2/20/14 at 12:11 p.m., Resident #38 had her meal tray in her room. A mug of coffee was on her tray. A clear mug with fluid increments marked on the side was on her bedside table containing 150 cc's of water. When queried, she indicated the staff brought her fresh cold water each shift.</p> <p>During an observation of 100 Hall on 2/20/14 at 3:30 p.m., Resident #38 had fresh ice water in her clear mug with fluid increments marked on the side. The mug contained 550 cc's of water. Resident #38's son who was also present in her room, indicated staff had just filled her mug with ice water.</p> <p>During an observation of the 100 Hall on 2/21/14 at 8:45 a.m., Resident #38 was up in bed eating her breakfast. Her breakfast tray consisted of a carton of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>milk and a mug of hot chocolate. There was also a clear mug with fluid increments marked on the side containing 500 cc's of ice water. When queried, Resident #38 indicated staff had just brought in the fresh ice water.</p> <p>During an observation of the 100 Hall on 2/21/13 at 12:15 p.m., Resident #38 was up in her wheelchair in her room eating her lunch off of a bedside table. Her lunch tray included of a mug of hot chocolate and a dish of ice cream. Her clear mug of water now contained 250 cc's. She also had a can of Pepsi on her bedside table.</p> <p>LPN #1, was interviewed on 2/20/14 at 4:10 p.m. During the interview she indicated Resident #38 took her medication whole with water.</p> <p>LPN #1, was interviewed on 2/21/14 at 2:15 p.m. During the interview she indicated Resident #38 received 240 cc's of water when she received her medications.</p> <p>The Director of Nursing was interviewed on 2/21/14 at 2:20 p.m. During the interview she indicated residents who had a physician's order for a fluid restriction should not have a water pitcher in their room.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>The Certified Dietary Manager was interviewed on 2/21/14 at 2:26 p.m. During the interview she indicated the cartons of milk used in the facility contained 8 ounces and the mugs used in the facility for hot chocolate contained 8 ounces.</p> <p>The Director of Nursing was interviewed on 2/24/14 at 10:25 a.m. During the interview she indicated Resident #38 had received more fluids than the 1500 cc's ordered per day. She also indicated the facility did not have a policy on following physician orders, but it was assumed the facility would follow physician orders.</p> <p>The Director of Nursing was interviewed on 2/24/14 at 11:15 a.m. During the interview she indicated the MatrixCare Report in the Medication Administration Record for Resident #38 did not "communicate" with the MatrixCare Report completed on the kiosk in the resident hallways. She also indicated the facility was not able to determine the total amount of fluid Resident #38 received in a day.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to re-assess, develop, and implement dietary interventions for 1 resident (Resident #82) of 7 residents who met the criteria for being underweight and not receiving a supplement. This deficient practice resulted in a severe weight loss for Resident #82.</p>	F000325	Heritage Park respectfully requests a face-to-face IDR due to disagreeing with the severity of this tag.F-325 It is the practice of this provider to endure underweight residents are re-assessed and dietary interventions are initiated when criteria is met. However, based on the alleged deficient practice the following has been implemented: What corrective	03/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
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	<p>Findings include:</p> <p>Review of the clinical record for Resident #82 on 2/24/14 at 2:37 p.m., indicated the following: diagnoses included, but were not limited to, depressive disorder, anxiety state, Alzheimer's disease, esophageal reflux, and nonorganic psychosis.</p> <p>A physician's order for Resident #82, dated 5/2/13, indicated she received a Regular Diet.</p> <p>A Dietary Progress Note for Resident #82, dated 6/24/13 and written by the Certified Dietary Manager (CDM), indicated a current weight of 117 pounds with a BMI (Body Mass Index) of 23.5 which was within recommended guidelines. The note also indicated she received a Regular Diet with an overall intake of 77%.</p> <p>A physician's order for Resident #82, dated 8/15/13, indicated to decrease Remeron from 30 mg (milligrams) HS (hour of sleep) to 15 mg HS. The original order for 30 mg Remeron was dated 9/1/10.</p> <p>A Dietary Progress Note for Resident #82, dated 9/5/13 and written by the</p>		<p>action(s) will e accomplished for those residents found to have been affected by the deficient practice: Resident #82 The Registered Dietician met with the Resident to determine individual likes/dislikes for appropriate nutritive interventions. Her tray card has been updated with preferences. During this interview- the Resident stated to the Dietician she "did not want to gain weight" and that she has "never been an eater". Se also stated her goal weight is 105-108 lbs. The Resident is provided a peanut butter sandwich daily, whole milk, a house milkshake in the afternoon BID. The Resident is encouraged to consume meals in the Dining Room- however; facility honors her preference of eating some meals in her room. No other resident were identified to have been affected by the alleged deficient practice. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Resident exhibiting a significant weight loss have the potential to be affected by the alleged deficient practice. The facility Registered Dietician reviewed current weight logs and found no other residents affected by the alleged deficient practice. The facility Nutrition At Risk Interdisciplinary Team has been re-educated on appropriate interventions regarding significant</p>		

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
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	<p>CDM, indicated a current weight of 119# with a BMI of 24 which was within recommended guidelines. The note also indicated she remained on a Regular Diet with an overall intake of 64%.</p> <p>A facility Vitals Report for Resident #82 indicated the following weights: 116 pounds on 5/1/13, 117 pounds on 6/7/13, 119 pounds on 7/1/13, 119 pounds on 8/1/13, 116 pounds on 9/6/13, 117 ponds on 10/4/13, and 117 pounds on 11/7/13.</p> <p>A Nutrition Risk Assessment for Resident #82, dated 11/24/13 and completed by the Registered Dietitian (RD), indicated she received a Regular Diet with ice cream at dinner. The assessment also indicated her current weight was 117 pounds with a usual body weight range of 114-119 pounds. The assessment further indicated she had a BMI of 17, which placed her weight status as underweight and her overall nutritional risk was high. The assessment indicated Remeron was prescribed as an appetite stimulant.</p> <p>A Nutrition Progress Note for Resident #82, dated 11/24/13 and written by the RD, indicated a weight of 117 pounds with a BMI of 17 (below recommended guidelines). The note also indicated she remained on a Regular Diet with ice</p>		<p>weight loss. Education includes but is not limited to reviewing weight logs weekly to identify weight loss and individualized interventions to reduce risk of further loss. The Resident weight logs are reviewed weekly by the Registered Dietician to determine any weight change. When weight loss is identified the Resident is placed on the NAR list for weekly monitoring by the Nutrition At Risk Interdisciplinary Team and an intervention is initiated to reduce the risk of further loss. The Interdisciplinary Team reviews the resident's weight and interventions weekly under the direction of the Registered Dietician to determine if they are successful. Further interventions are initiated as indicated. The Registered Dietician is responsible for compliance. Education provided by the Corporate Dietician on March 7, 2014. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: Resident weight logs are reviewed weekly by the Registered Dietician to determine any weight change. Identified weight loss places the Resident on the Nutrition At Risk list for weekly monitoring by the Nutrition At Risk Interdisciplinary Team and an intervention is initiated to reduce the risk of further loss. The facility Nutrition At Risk Interdisciplinary Team has been</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD 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	
	<p>cream at dinner and an overall intake of 50%. The note further indicated she received Remeron as an appetite stimulant. No recommendations were made.</p> <p>A facility Vitals Report for Resident #82 indicated the following weights: 116 pounds on 12/4/13, 111 pounds on 1/3/14, 111 pounds on 1/24/13, 109 pounds on 1/31/14, 109 pounds on 2/5/13, and 105 pounds on 2/14/14.</p> <p>Based on facility weights, Resident #82's weight had decreased 8 pounds from 11/7/13 to 1/31/14, or 6.8%, indicating a severe weight loss and had decreased 14 pounds from 8/1/13 to 2/14/14, or 11.76%, indicating a severe weight loss.</p> <p>There were no additional Dietary or Nutrition Progress Notes or Nutrition Risk Assessment for Resident #82 since 11/24/13 available in the clinical record addressing her weight loss.</p> <p>A Meal Tray Card for Resident #82, provided by the CDM on 2/24/14 at 3:15 p.m., indicated she received a Regular Diet with ice cream at dinner. The tray card did not include any additional dietary interventions.</p> <p>A facility care plan for Resident #82,</p>		<p>re-educated on appropriate interventions regarding significant weight loss. Education includes but is not limited to reviewing weight logs weekly to identify weight loss and individualized interventions to reduce risk of further loss. The Resident weight status and interventions are reviewed weekly by the Nutrition at Risk Interdisciplinary Team under the direction of the Registered Dietician to determine if implemented interventions are successful. Further interventions are initiated as indicated. The Registered Dietician is responsible for compliance. Education provided by the Corporate Dietician on March 7, 2014. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A CQI monitoring tool titled "Weight Loss" will be utilized every week x 4, monthly x 3 and quarterly thereafter Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will e developed Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805			
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	<p>with a start date of 11/13/13, indicated the problem area of potential for altered nutritional status due to varied food and fluid intake. The goal to the problem was the resident would tolerate current diet with no significant weight changes. Approaches to the problem included, but were not limited to, Regular Diet, snacks available between meals, provide Remeron as ordered, monitor food/fluid intake at meals, monitor weight, notify MD/family of significant weight changes, and offer substitute if <75% of any meal was consumed.</p> <p>Resident #82 was interviewed on 2/24/14 at 2:50 p.m. During the interview she indicated she had informed the facility kitchen of the foods she did not like, but they kept sending them to her anyway. She also indicated she just never ate those foods sent to her.</p> <p>The RD was interviewed on 2/24/14 at 4:22 p.m. During the interview she indicated facility weights were recorded and given to her by 7th day of the month. She also indicated she then put the weight into the computer to determine any trends in weight loss. She further indicated she had noticed a trending weight loss for Resident #82.</p> <p>The RD was interviewed on 2/24/14 at</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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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>4:47 p.m. During the interview she indicated Resident #82 had been missed and not added to the NAR (Nutrition at Risk) program. She also indicated no additional dietary interventions had been started for Resident #82 after her severe weight loss.</p> <p>A current facility policy "Resident Weight Monitoring", revised on April, 2011, and provided by the CDM on 2/24/14 at 3:53 p.m., indicated "...Upon obtaining monthly weights and entering them onto the log, a monthly weight change report is distributed by the 7th day of the month to the following individuals: a. Director of Nursing Services b. Registered Dietitian c. Dietary Services Manager/Dietary Clinician d. MDS Coordinator...The Dietary Services Manager/Dietary Clinician and Director of Nursing Services (or designee) review the resident weight log no less than monthly. The Interdisciplinary Team (IDT) will be alerted to residents who have weight and/or nutritional concerns...Residents who have experienced significant...weight loss...will be brought to the attention of the Interdisciplinary Team. The team reviews possible medical, physical, social, or psychological reasons for the weight loss...and develops a care plan to reverse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>the condition...."</p> <p>A current facility policy "NAR Expectations", revised on September, 2013, and provided by the RD on 2/24/14 at 4:48 p.m., indicated "...Residents who trigger for significant weight loss (30, 90 or 180d) will be placed on weekly weights and an initial IDT not will be written...If weekly weights show a loss, the resident's nutritional status is reviewed and an IDT note will be written...."</p> <p>3.1-46(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview and record review, the facility failed to ensure palatable food temperatures and/or textures were maintained for 3 of 39 residents, who ate in their rooms, for 1 of 1 meal temperatures checked.</p> <p>Resident #227 Resident #106 Resident #40</p> <p>Findings include:</p> <p>1. On 2/20/14 at 9:45 A.M., Resident #227 was interviewed. She indicated this</p>	F000364	<p>F-364It is the practice of this provider to ensure palatable food temperatures and/or textures are maintained. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #227Meals served to Resident are of palatable temperature and textureResident #106Meals served to Resident are of palatable temperature and textureResident #40Meals served to Resident are of palatable</p>	03/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD 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			
	<p>morning for breakfast, she received biscuits and gravy on her tray. She indicated the biscuit was "hard as a rock and the sausage gravy was cold." Resident #227 indicated CNA #44(Certified Nursing Assistant), who served her the breakfast tray, had indicated she was aware the biscuits were hard.</p> <p>On 2/20/14 at 2 P.M., CNA #44 was interviewed. She indicated she had cut up several resident's biscuits at breakfast and some of the biscuits were hard in texture.</p> <p>On 2/21/14 at 12:10 P.M., the meal trays to be served to residents, who ate in their rooms on the 700 and 600 halls, were placed in the covered tray cart. The covered tray cart was metal and did not have a mechanism to be plugged in as a source of heat to maintain meal tray temperatures. These trays had been prepared in the kitchen, which was located off the dining room on the North Unit (600/700/800 900 halls). At the time, the tray service had begun to the resident rooms.</p> <p>At 12:13 P.M., a thermometer was obtained from the Dietary Staff #33. At 12:18 P.M., the Dietician checked the temperature of the last meal tray served</p>		<p>temperature and textureNo other residents were identified to have been affected by the alleged deficient practice How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:Residents receiving oral diets have the potential to be affected by the alleged deficient practice. Additional equipment including insulated tray carts and a plate warmer have been obtained to decrease the risk of significant changes in food temperatures for hall trays.Staff have been re-educated on appropriate temperature and palatability of meals.Education includes but is not limited to following preparation guidelines, obtaining food temperature prior to serving, palatable temperature ranges and timeliness of meal service.Assigned Department Managers monitor temperatures throughout the meal service to ensure food temperatures are appropriate. Education provided by the Certified Dietary Manager and Clinical Education Co-ordinator March 11, 2014.This provider has scheduled a consult on March 11, 2014 with CT Designs (an institutional kitchen design specialty company) for recommendations in redesigning the facility kitchen and unit kitchenettes to allow an improved process in serving meals. What measures will be put into place or</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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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>on the 600 hall. The Dietician used the thermometer provided by Dietary Staff #33. The Dietician checked the temperature of the chicken breast on the tray and read the temperature as 120 degrees Fahrenheit. At the time, the Dietician opened the carton of milk on the tray, inserted the thermometer and read the milk temperature at 43 degrees.</p> <p>On 2/21/14 at 1 P.M. a copy of the Resident Council Meeting Minutes was received from the Administrator (Adm). The 2/5/14 minutes included, but were not limited to, the following: "Dietary...temps (temperatures) of food received still remain a problem." The 1/22/14 minutes included, but were not limited to, the following: "...meals are still not coming to some residents as hot (sic) as they would like." The 12/18/13 minutes included, but were not limited to, the following: "...Dietary-would like a rep (representative) from the kitchen at the next meeting..."</p> <p>On 2/21/14 at 1:04 P.M., a copy of the current policy and procedure for "Food Temperatures" was received from the Dietitian. The policy and procedure was dated as most recently revised on 4/2011. The policy included, but was not limited to, the following: "...temperatures should be taken...periodically during the meal</p>		<p>what systemic changes you will make to ensure that the deficient practice does not recur:Additional equipment including insulated tray carts and a plate warmer have been obtained to decrease the risk of significant changes in food temperatures for hall trays.Staff have been re-educated on appropriate temperature and palatability of meals. Education includes but is not limited to following preparation guidelines, obtaining food temperature prior to serving, palatable temperature ranges and timeliness of meal service.Assigned Department Managers monitor temperatures throughout the meal service to ensure food temperatures are appropriate. Education provided by the Certified Dietary Manager and Clinical Education Co-ordinator March 11, 2014.This provider has scheduled a consult on March 11, 2014 with CT Designs (an institutional kitchen design specialty company) for recommendations in redesigning the facility kitchen and unit kitchenettes to allow an improved process in serving meals.The Certified Dietary Manager is responsible for compliance.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:A CQI monitoring tool titled "Meal Palatability" will be utilized every week x 4, monthly x 6 and quarterly thereafterData will be submitted to the CQI Committee</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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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>service to ensure hot foods stay above 135 degrees F (Fahrenheit) and cold food stay below 41 degrees F during the portioning, transporting and serving process until received by the resident.</p> <p>On 2/24/14 at 2 P.M., the Adm was interviewed. She indicated the facility had identified the food temperatures as an issue and were in the process of purchasing equipment to aid in maintaining food temperatures on the meal trays. The Adm indicated the facility had just purchased the "pellet bases." She indicated these were devices which were placed under the plates to "help hold the temperature in." The Adm also indicated the facility was "pricing the carts you plug in to maintain the temps."</p> <p>On 2/24/14 at 4:58 P.M. a resident was interviewed confidentially. She indicated the food served to residents in their rooms was sometimes cold. She indicated the food served from the meal carts to residents in their room, has been cold "for at least 6 months." She indicated the staff in the kitchen was aware the food was cold and were "trying to fix it."</p> <p>2. An interview with Resident #106 on 2/18/14 at 4:23 p.m. indicated the food is</p>		<p>overseen by the Executive Director. If threshold of 95% is not met, an action plan will e developedNon-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD 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	
F000371 SS=E	<p>usually cooled down by the time I get it. He indicated he is usually the last one served in the dining room and also indicated the plates of food remain on the counter waiting to be served to the residents.</p> <p>3. An interview with Resident #40 on 2/19/14 at 3:11 p.m. indicated the food is never warm. The Resident indicated she eats breakfast in her room and the other meals in the dining room.</p> <p>3.1-21(a)(1) 3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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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>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility failed to protect clean dishes, clean bowls, clean divided plates, clean flow control cups, and clean silverware from contamination when transported from the facility kitchen to the facility dining rooms potentially affecting 26 residents who ate their meals in the Auguste's Cottage dining room, 25-28 residents who ate their meal in the 200 Hall dining room, and 20-25 residents who ate their meals in the Moving Forward dining room. The facility further failed to ensure their policy and procedure for Restriction of Kitchen to Authorized Staff was followed.</p> <p>Findings include:</p> <p>1. During an observation on 2/18/14 at 3:49 p.m., Dietary Aide #2 was observed transporting 2 open tiered carts from the facility kitchen through the 500 Hall to the entrance to the Auguste's Cottage. The first open cart, which was moved into the Auguste's Cottage by Dietary Aide #2, contained a stack of 26 dinner plates, a stack of 26 bowls, 4 flow control cups, and 3 divided plates. None of the items were covered to protect them from contamination. The second open cart,</p>	F000371	<p>F-371It is the practice of this provider to ensure dinnerware is protected from contamination when transported throughout facility and to ensure unauthorized staff do not enter the kitchen area. However, based on the alleged deficient practice the following has been implemented:What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident in facility:Meal dinnerware is transported to dining room destinations in covered carts.Staff do not enter unauthorized areas of the building.Employee #6:Disciplinary action was taken dated February 23, 2014 due to employee being unauthorized to enter the kitchen area.Re-education was provided to this employee. Education was provided includes potential risks and hazards of entering unauthorized areas of the building. Education provided by the Clinical Education Co-ordinator on February 23, 2014.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:Residents eating meals served from stationary steam tables in dining areas have the potential to be affected by the alleged deficient practice.Dietary staff have bee</p>	03/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD 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	
	<p>which remained in the hallway for several minutes before being transported through the 100 Hall and the 200 Hall to the 200 Hall dining room by unidentified nursing personnel, contained a stack of 26 dinner plates, 4 flow control cups, and 2 divided plates. None of the items were covered to protect them from contamination. At 4:05 p.m., the open tiered cart which had been moved into the Auguste's Cottage was left in the common area in front of the kitchenette where residents walked by. The dinner plates, bowls, flow control cups, and divided plates remained uncovered.</p> <p>2. During an observation on 2/19/14 at 4:40 p.m., Dietary Aide #3 was observed pushing an open tiered cart from the facility kitchen through the 600 Hall to the Moving Forward dining room. A divided silverware bin containing clean knives, forks, and spoons was observed on the cart. The bin was not covered to protect the silverware from contamination.</p> <p>3. During an observation on 2/20/14 at 10:50 a.m., Dietary Aide #4 was observed transporting 2 open tiered carts from the facility kitchen through the 500 Hall. Both carts contained stacks of clean dinner plates. One cart was moved into the Auguste's Cottage. The other</p>		<p>re-educated on prevention of contamination while transporting dinnerware. Education includes but is not limited to ensuring clean dinnerware is covered appropriately before leaving the kitchen. Education provided by Registered Dietician, Certified Dietary Manager and Clinical Education Co-ordinator by March 11, 2014. Signs have been posted on Dietary doors indicating the area is for "Authorized Personnel Only" Staff have been re-educated on entering an unauthorized area in the facility. Education included but is not limited to potential risks and hazards of entering these areas and locations in the building that are unauthorized to individual departments. Education provided by the Clinical Education Co-ordinator by March 11, 2014. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Dietary staff have been re-educated on the prevention of contamination while transporting dinnerware. Education includes but is not limited to ensuring clean dinnerware is covered appropriately before leaving the kitchen. Education provided by Registered Dietician, Certified Dietary Manager and Clinical Education Co-ordinator by March 11, 2014. Dietary Supervisors will monitor carts prior to the carts leaving the kitchen to ensure they</p>		

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD 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	
	<p>cart was moved through the 100 Hall and the 200 Hall to the 200 Hall dining room. Neither cart was covered to protect the stacks of clean dinner plates from contamination.</p> <p>4. During an observation on 2/21/14 at 11:34 a.m., Dietary Aide #5 was observed pushing an insulated cart from the facility kitchen through the 600 Hall to the Moving Forward dining room. A divided silverware bin containing clean knives, forks, and spoons was observed on top of the insulated cart. The bin was not covered to protect the silverware from contamination.</p> <p>5. During an observation on 2/21/14 at 11:48 a.m. in the facility kitchen, the back door of the kitchen to the outside opened and a woman in street clothes carrying a baby entered the kitchen. She proceeded to walk through the kitchen during meal service and exited the kitchen door leading into the dining room.</p> <p>The Certified Dietary Manager (CDM) was interviewed immediately following. During the interview she indicated the woman who used the kitchen as a short cut into the facility used to work in the dietary department. The CDM also indicated she should not be in the</p>		<p>are covered appropriately. Signs have been posted on Dietary doors indicating the area is for "Authorized Personnel Only" Staff have been re-educated on entering an unauthorized area in the facility. Education included but is not limited to potential risks and hazards of entering these areas and locations in the building that are unauthorized to individual departments. Education provided by the Clinical Education Co-ordinator by March 11, 2014. The Certified Dietary Manager is responsible for compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A CQI monitoring tool titled "Dietary Infection Control" will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
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	<p>kitchen. The CDM identified her as Certified Nursing Assistance #6.</p> <p>The Consultant Registered Dietitian was interviewed on 2/21/14 at 2:03 p.m. During the interview she indicated clean items transported from the facility kitchen should be covered to prevent possible contamination.</p> <p>A current facility policy "General Food Preparation and Handling", revised on April, 2011 and provided by the CDM on 2/21/14 at 2:12 p.m., indicated "... Any utensils or dishware transported to other areas will either be covered or placed in covered containers/enclosed carts...."</p> <p>A current facility policy "Restriction of Kitchen to Authorized Staff", revised on May, 2006 and provided by the CDM on 2/21/14 at 2:12 p.m., indicated "...The kitchen is restricted to any person who has direct resident contact...Any person who has direct resident contact should not come into the kitchen or serving area...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure the proper labeling of Over the Counter Medications and topicals; medications were not dated when opened, and removal of expired medications and/or medications of discharged residents from the medications carts. The facility also failed to keep medication and treatment carts clean for 4 of 9 medication carts and 2 of 7 treatment carts observed. The facility further failed to ensure the removal of expired enteral feedings from 1 of 2 medication storage rooms. This affected Resident #117, Resident #105, Resident #9, Resident #23, Resident #18, Resident #257, Resident #248, Resident #166, and Resident #218.</p> <p>Findings include:</p> <p>1. An observation of the 900 hall medication and treatment cart with LPN #7 on 2-24-2014 at 10:30 a.m., indicated the following over the counter medication and topicals were not labeled with a resident name:</p>	F000431	<p>F-431It is the practice of this provider to ensure over the counter medications are labeled appropriately, multi-dose medications are dated when opened, medications and enteral feedings that are expired or of discharged residents are removed from carts/medication room and the medication/treatment carts are clean. However, based on the alleged deficient practice the following has been implemented:What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #117The expired insulins were discardedResident #105The expired insulin was discardedResident #23The inhaler was discardedResident #18The eardrops were discardedResident #257The liquid vitamin was discardedResident #166The ointment was discardedResident #218The cream was discardedResident #248The liquid medication was discardedNo other residents were identified to have been affected b the alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what</p>	03/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
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	<p>-a container of Tums 750 mg (milligrams) tablets</p> <p>-a tube of PeleVerus ointment</p> <p>-a tube of hydrocortisone cream 2.5%</p> <p>-a small bottle of Hibiclens</p> <p>Inside the treatment cart, the compartments had loose debris scattered and a sticky, brown color residue on the bottom and side of the compartment in the front, left corner of the cart.</p> <p>An interview with LPN #7 on 2-24-2014 at 10:31 a.m., indicated LPN #7 could not identify which residents the Tums or the topicals belonged. LPN #7 indicated the Tums and the topicals should have been labeled with a resident name. In addition, LPN #7 could not identify the sticky, brownish residue in the treatment cart and indicated the medication and treatment carts should be cleaned nightly.</p> <p>An interview with RN Unit Manager #8 on 2-24-2014 at 11:25 a.m., indicated the medication and</p>		<p>corrective action will be taken:Resident's receiving medications or treatments have the potential to be affected by the alleged deficient practice.The medication/treatment rooms have been cleaned and inappropriate medication/treatments disposed of.The medication and treatment carts were audited by the DNS/Designee to ensure medications/treatments in the carts are appropriate and carts were disinfected.Licensed Nursing Staff have been re-educated on cleanliness of medication/treatment carts and appropriate labeling and dating of medications. Education included but is not limited to dating the multi-dose medications with the "Opened and Expiration" dates, scheduled cleaning and maintaining cleanliness of medication and treatment carts, disposition and reconciliation of medications and treatments.A cleaning schedule has been implemented to ensure medication/treatment carts and medication rooms are routinely cleaned.A Medication Expiration Graph and yearly calendar is available on each medication/treatment cart for Licensed Staff reference.Education provided by the DNS/Clinical Education Co-ordinator by March 11, 2014.The Unit Managers/Designee are responsible for oversight. What</p>		

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
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	<p>treatment carts should be cleaned nightly. RN #8 was unable to identify the sticky, brown color residue on the bottom and side of the compartment in the front, left corner of the 900 hall treatment cart and indicated the cart should have been cleaned by the night shift.</p> <p>An interview with RN Unit Manager #8 on 2-24-2014 at 11:37 a.m., indicated the facility did not have a policy for the cleaning of the the medication and treatment carts, but the expectation was for the carts to be cleaned nightly.</p> <p>A policy "Labeling of Medication" dated 7/2011 provided by the DON (Director of Nursing) on 2-24-2014 at 1:30 p.m., indicated "...labeling for all medications must be typed or printed and clearly indicate...resident/patient full name, prescription number, name and strength of drug, routine and time(s) the medication is to be given (if indicated on the prescription order), quantity of drug/medication dispensed, date dispensed, expiration date of all time dated drugs, prescriber's name, the name, address, and telephone number of the</p>		<p>measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:Licensed Nursing Staff have been re-educated on cleanliness of medication/treatment carts and appropriate labeling and dating of medications. Education included but is not limited to dating the multi-dose medications with the "Opened and Expiration" dates, scheduled cleaning and maintaining cleanliness of medication and treatment carts, disposition and reconciliation of medications and treatments.A cleaning schedule has been implemented to ensure medication/treatment carts and medication rooms are routinely cleaned.The DNS/Designee conducts an audit weekly to ensure carts are clean and medications/treatments are labeled and removed from carts appropriately. A Medication Expiration Graph and yearly calendar is available on each medication/treatment cart for Licensed Staff reference.Education provided by the DNS/Clinical Education Co-ordinator by March 11, 2014.The Unit Managers/Designee are responsible for oversight.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:A CQI monitoring tool titled "Medication/Treatment Storage"</p>		

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>dispensing pharmacy...."</p> <p>An interview with the DON on 2-24-2014 at 1:40 p.m., indicated the "Labeling of Medication" policy revised on 7/2011 would include over the counter medications.</p> <p>2. An observation of the Medication Storage room which served the 600-900 halls with LPN #9 on 2-24-2014 at 10:55 a.m., indicated the following:</p> <ul style="list-style-type: none"> -10 liter bottles of Jevity 1 cal with the use by date of February 1, 2014 were on the ready to use shelf. -1 liter bottle of Jevity 1 cal with the use by date of August 1, 2013 was on the ready to use shelf. -1 can of Jevity 1.2 with the use by date of January 1, 2014 was on the ready to use shelf. <p>An interview with LPN #9 on 2-24-2014 at 10:56 a.m., indicated the 11 bottles and 1 can were expired.</p> <p>An interview with RN Unit Manager #8 on 2-24-2014 at 10:57 a.m., indicated dietary placed the bottles</p>		<p>will be utilized every week x 4, monthly x 6 and quarterly thereafterData will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will e developedNon-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>on the shelf and nursing was supposed to check the bottles/can for expiration/use by date prior to administration to a resident and return any expired Jevity. RN #8 was unable to explain how the expired Jevity remained on the ready to use shelf.</p> <p>An interview with RN Unit Manager #8 on 2-24-2014 at 11:37 a.m., indicated there was not a policy that addressed the expired Jevity. RN #8 indicated any expired Jevity was to be sent back.</p> <p>3. During an observation on 2/24/14 at 10:15 a.m., two medications were found to be expired on the 200 Hall medication cart. The expired medications included the following: -For Resident #117, Lantus Insulin (for Diabetes) was labeled with an open date of 1/18/14. The vial of Lantus Insulin was not labeled with a "Do Not Use After" expiration date. -Also for Resident #117, Humalog Insulin (for Diabetes) was labeled with an open date of 1/17/14. The vial of Humalog Insulin was not labeled with a "Do Not Use After" expiration date.</p> <p>During an interview with LPN #13</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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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>on 2/24/13 at 10:25 a.m., she indicated she was not sure when the insulins should be discarded. After LPN #13 looked for the facility policy, she indicated she thought the insulin should be discarded 30 days after it was opened.</p> <p>A review of Resident #117 's EMAR(Electronic Medication Administration Record) Medication Documentation provided by the DON (Director of Nursing) on 2/24/14 at 1:30 p.m., indicated the following:</p> <ul style="list-style-type: none"> -Lantus insulin was given to the resident 7 times after the expiration date (28 days after open date) of 2/14/14. -Humalog Insulin was given 34 times after the expiration date of 2/13/14. <p>4. During an observation on 2/24/14 at 11:00 a.m., one medication was found to be expired on the 500 Hall medication cart. The expired medication included the following:</p> <ul style="list-style-type: none"> -For Resident #105 , Humalog Insulin was labeled with a open date of 1/10/14. The vial of Humalog Insulin was not labeled with a "Do Not Use After" expiration 			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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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>date.</p> <p>During an interview with RN #11, the Unit Manager, on 2/24/14 at 11:05 a.m., she indicated the Humalog Insulin was expired. She indicated the resident received the Humalog Insulin after meals.</p> <p>A review of Resident #105 's EMAR Medication Documentation provided by DON on 2/24/14 at 1:30 p.m., indicated the following: -Humalog Insulin was given 50 times after the expiration date of 2/7/14.</p> <p>A review of the undated policy used by the facility from the contracted Pharmacy, Medications Requiring Special Storage...Injectables, provided by DON on 2/24/14 at 2:43 p.m. indicated the following: "...Humalog...Expires 28 days after removing from the refrigerator opened or un-opened...." "...Lantus...Expires 28 days after removing from refrigerator opened or un-opened...."</p> <p>5. During an observation on 2/24/14 at 11:40 a.m., of the 200 Hall treatment Cart, 4 tubes of treatment ointments and creams</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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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>were found to be without labels to identify the resident they belonged to. The unlabeled treatment ointments/creams included the following:</p> <ul style="list-style-type: none"> - 2 tubes of Vasolex Ointment (a treatment to promote wound healing of pressure and varicose ulcers and dehiscent wounds) was not labeled with a resident's name. -2 tubes of Geri Hydrolac (a treatment for dry, scaly, itchy skin) was not labeled with a resident's name. <p>Interview with RN #11 on 2/24/14 at 11:45 a.m., indicated she could not determine which resident the treatment ointments and creams belonged to and she also indicated the tubes should have been labeled with the Resident's name. RN #11 indicated the night shift nurse is responsible to keep the medication and treatment carts clean.</p> <p>6. On 2/24/14 at 10:30 A.M., the 700 Hall medication (med) cart was observed with LPN #15. On the side of the cart, were open bins, in which stacked medication cups were stored. The stack of med cups was stored so the wide, opened side of the med cup was</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD 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
	<p>contacting the base of the bin on the side of the med cart. A hair was observed draped along the medication cup stack, contacting the exposed edges of the med cups. Dust was observed in the base of the storage bins containing the med cups, straws and spoons on the side of the med cart. At the time the following was observed in the medication cart: Besivance eye drops, which had the name of Resident #9 on the label, had no open date documented on the bottle and there was also no seal observed to the bottle neck and/or lid; a Proventil inhaler with the name of Resident #23 was not dated when it was opened.</p> <p>On 2/24/14 at 10:35 A.M., the 600 Hall med cart was observed with LPN #15. The following was observed: Ear drops with the name of Resident #18 were observed with no date when the bottle had been opened; and scattered on interior surfaces of the drawers of the cart, were dried spatters and dust of various colors.</p> <p>On 2/24/14 at 10:40 A.M., the 800 Hall med cart was observed with LPN #16. The interior surface of the top drawer was observed with</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
---	---

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	<p>dried orange spills in the base of the drawer. A bottle of liquid Cerovite, which had the name of Resident #257 on it, had not been dated when it was opened. The interior surface of the third drawer from the top, was also observed with dried spills in the base and sides as well as various colors of dust noted on the interior surface of the drawer. A bottle of Milk of Magnesia, with the name of Resident #248, had not been dated when it had been opened.</p> <p>On 2/24/14 at 11:20 A.M., the 800 Hall treatment cart was observed with LPN #17. In the top drawer of the treatment cart, the following was observed: two tubes each of Vasolex ointment and Xenaderm, which were opened but not dated as to when they had been opened; one tube of Hydrocortisone ointment, with the name of Resident #166, who LPN #17 indicated had been discharged on 12/31/13; an opened tube of Silvadene cream, which LPN #17 identified to have belonged to Resident #218. LPN #17 indicated Resident #218 had expired approximately a month ago. This tube of cream was not labeled with a name and/or a date it had been</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>opened. A bottle of wound cleanser, with the label "Exsept", had no identifying resident name or date it had been opened. LPN #17 indicated this bottle of Exsept, "comes back with the resident from dialysis." The drawer also contained an open tube of Zinc ointment, which had not been labeled with a resident name.</p> <p>On 2/24/14 at 1:30 P.M., the policy and procedure titled "Disposition of Medications when a Resident is Discharged from the Facility" was dated as revised 7/2011. The policy included, but was not limited to, the following: "...Upon discharge from the facility, the patient's drugs are to: Be released with the patient, or be returned to the pharmacy...or be destroyed by two licensed nursing personnel..."</p> <p>On 2/24/14 at 1 42 P.M., the DON (Director of Nursing) was interviewed. She indicated the medications which belonged to the resident who was discharged on 12/31/13, should not have still been in the treatment cart, in her opinion. She indicated when a resident is expired and/or discharged, the treatments and medications should be pull from</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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F000514 SS=D	<p>the medication and /or treatment cart. She indicated the facility policy doesn't specify a time frame the removal of these items is to be completed.</p> <p>3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(r)</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 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>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805			
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	<p>Based on interview and record review, the facility failed to maintain accurate and complete documentation on fluid intakes for 1 resident (Resident #38) of 1 resident reviewed for dialysis and narcotic count documentation for 1 resident (Resident #256).</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #38 on 2/20/14 at 9:56 a.m., indicated the following: diagnoses included, but were not limited to, CHF (congestive heart failure), chronic kidney disease Stage III, and diabetes mellitus.</p> <p>A physician's order for Resident #38, dated 1/29/14, indicated a Consistent Carbohydrate No Added Salt diet with double meat. The order also indicated a fluid restriction of 1500 cc's (cubic centimeters) - 240 ml (milliliter) with meals, 300 ml on 1st shift, 300 ml on 2nd shift, and 180 ml on 3rd shift.</p> <p>A physician's order for Resident #38, with a start date of 2/3/14, indicated Nepro, 1 can with AM med pass.</p> <p>A MatrixCare Report as part of the Medication Administration Record for Resident #38, indicated fluids were</p>	F000514	F 514 It is the practice of this provider to ensure documentation on fluid intakes and narcotic counts are complete and accurate. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #38 Education was immediately provided to Resident and Responsible Party on possible negative effect of continued fluid restriction non-compliance. The fluid restriction was discontinued by the physician due to the Resident and Responsible Party's desire to keep liquids at bedside and their desire to allow the Resident to choose what and how much to drink at meals. this provider continues to honor Resident's choice to consume fluids as desired. Resident #256 The narcotic medication was accounted for/signed out by the administering licensed nurse. The resident received the medication as ordered. All narcotics were accounted for. No other residents were found to have been affected by the alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents with a physicians order for a fluid restriction and Residents receiving narcotic medications	03/14/2014			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>recorded: during the 6:00 AM - 2:00 PM shift for amount with meals and amounts between meals; during the 2:00 PM - 10:00 PM shift for amount with meals and amounts between meals; and during the 10:00 PM - 6:00 AM shift for amount between meals. The MatrixCare Report also indicated the fluid total with meals, the fluid total between meals, and the 3 shift fluid total were recorded. The following amounts were recorded:</p> <p>- On February 1, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 249 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 240 cc's between meals 10:00 PM - 6:00 AM - 240 cc's between meals Total with meals - 720 cc's Total between meals - 780 cc's 3 Shift Fluid Total - 1500 cc's</p> <p>- On February 2, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 120 cc's between meals 2:00 PM - 10:00 PM - 133 cc's with meals, 240 cc's between meals 10:00 PM - 6:00 AM - 240 cc's between meals Total with meals - 300 cc's Total between meals - 180 cc's 3 Shift Fluid Total - 1500 cc's</p>		<p>have the potential to be affected by the alleged deficient practice A completed audit for resident's on a fluid restriction and residents receiving narcotic medication indicated no other residents were identified to have been affected by the alleged deficient practice. Narcotic Drug Logs and Controlled Drug Audit Forms ere reviewed for discrepancies. No other discrepancies were identified. Nursing staff have been re-educated on required documentation for Residents with a physician ordered Fluid Restriction. Education includes but is not limited to documentation requirements for calculating meal fluids, med pass fluids and supplement fluids accurately and reflecting accurate totals on the Resident Consumption Log in Matrix and accurately reflecting totals on the Fluid Restriction Log in EMAR. Licensed staff have been re-educated on narcotic drug administration. Education includes but is not limited to signing out narcotics at the point of administration, counting narcotic medication shift to shift and signing in/out on the Controlled Drug Audit. Education provided by DNS and Clinical Education Co-ordinator completed March 10, 2014. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Nursing</p>	

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	<p>- On February 3, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 240 cc's between meals 10:00 PM - 6:00 AM - 120 cc's between meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 4, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 120 cc's between meals 10:00 PM - 6:00 AM - 120 cc's between meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 5, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 240 cc's between meals 10:00 PM - 6:00 AM - 120 cc's between meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 6, 2014:</p>		<p>staff have been re-educated on required documentation for Residents with a physician ordered Fluid Restriction. Education includes but is not limited to documentation requirements for calculating meal fluids, med pass fluids and supplement fluids accurately and reflecting accurate totals on the Resident Consumption Log. The DNS/Designee will review charge nurse documentation to ensure physician orders are followed for fluid intake Licensed staff have been re-educated on narcotic drug administration. Education includes but is not limited to signing out narcotics at the point of administration, counting narcotic medication shift to shift and signing in/out on the Controlled Drug Audit. Education provided by DNS and Clinical Education Co-ordinator completed March 10, 2014. The Licensed Unit Managers/Designee is responsible for compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: CQI monitoring tools titled "Narcotic Medication Administration" and "Fluid Restriction" will be utilized every week x 4, monthly x 6 and quarterly thereafter Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will e developed Non-compliance with</p>	

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805			
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	<p>6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 300 cc's between meals 10:00 PM - 6:00 AM - 120 cc's with meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 7, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 120 cc's between meals 2:00 PM - 10:00 PM - 120 cc's with meals, 120 cc's between meals 10:00 PM - 6:00 AM - 240 cc's between meals Total with meals - 240 cc's Total between meals - 240 cc's 3 Shift Fluid Total - 1500 cc's</p> <p>- On February 8, 2014: 6:00 AM - 2:00 PM - no documentation of fluids with meals or between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 266 cc's between meals 10:00 PM - 6:00 AM - 240 cc's between meals Total with meals - 300 cc's Total between meals - 180 cc's 3 Shift Fluid Total - 1500 cc's</p> <p>- On February 9, 2014:</p>		<p>facility procedure may result in disciplinary action up to and including termination.</p>				

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>6:00 AM - 2:00 PM - 240 cc's with meals, 120 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 240 cc's between meals 10:00 PM - 6:00 AM - 240 cc's between meals Total with meals - 300 cc's Total between meals - 400 cc's 3 Shift Fluid Total - 1500 cc's</p> <p>- On February 10, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 300 cc's between meals 10:00 PM - 6:00 AM - 120 cc's between meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 11, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 300 cc's between meals 10:00 PM - 6:00 AM - 120 cc's between meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 12, 2014: 6:00 AM - 2:00 PM - 240 cc's with</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 300 cc's between meals 10:00 PM - 6:00 AM - 120 cc's between meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 13, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 300 cc's between meals 10:00 PM - 6:00 AM - 120 cc's between meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 14, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 120 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 300 cc's between meals 10:00 PM - 6:00 AM - 0 Total with meals - 0 Total between meals - 0 3 Shift Fluid Total - 180 cc's</p> <p>- On February 15, 2014: 6:00 AM - 2:00 PM - 120 cc's with meals, 120 cc's between meals 2:00 PM - 10:00 PM - 120 cc's with</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>meals, 120 cc's between meals 10:00 PM - 6:00 AM - 240 cc's between meals Total with meals - 480 cc's Total between meals - 300 cc's 3 Shift Fluid Total - 1500 cc's</p> <p>- On February 16, 2014: 6:00 AM - 2:00 PM - 120 cc's with meals, 120 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 240 cc's between meals 10:00 PM - 6:00 AM - 240 cc's between meals Total with meals - 300 cc's Total between meals - 300 cc's 3 Shift Fluid Total - 1500 cc's</p> <p>- On February 17, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 300 cc's between meals 10:00 PM - 6:00 AM - 120 cc's with meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 18, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 200 cc's between meals</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>10:00 PM - 6:00 AM - 120 cc's between meals Total with meals - 0 Total between meals - 120 cc's 3 Shift Fluid Total - 120 cc's</p> <p>- On February 19, 2014: 6:00 AM - 2:00 PM - 240 cc's with meals, 300 cc's between meals 2:00 PM - 10:00 PM - 240 cc's with meals, 300 cc's between meals 10:00 PM - 6:00 AM - NA Total with meals - NA Total between meals - NA 3 Shift Fluid Total - 180 cc's</p> <p>The Director of Nursing was interviewed on 2/24/14 at 2:16 p.m. During the interview she indicated the facility did not have a policy on the documentation of fluid intake. She also indicated blanks in the documents indicated staff did not enter the information.</p> <p>2. On 2/24/14 at 10:40 a.m., a review of Controlled Substance Count on 100 Hall Medication Cart with QMA #12, Resident #256's Oxycodone-Acetaminophen 5-325 mg count did not match the Controlled Substance Sign Out record. The actual count of pills was 7 and the record indicated 11. QMA #12 indicated she found the medication count was off when</p>			

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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	<p>she signed out Oxycodone-Acetaminophen 2 tablets for Resident #256 at 7:00 a.m. today. QMA #12 also indicated she did not do the narcotic count this morning when she started work. She indicated the nurses should have done the narcotic count at shift change.</p> <p>On 2/24/14 at 10:45 a.m. a review of the Controlled Drug Audit dated, February 2014, indicated there were no signatures of nurses' to indicate the controlled medications were counted at shift change on 2/24/14.</p> <p>On 2/24/14 at 10:55 a.m. an interview with RN #11, Unit Manager, indicated the narcotic count should be done every shift change and nurses' should sign the record when the count was done.</p> <p>On 2/24/14, LPN #10 provided a copy of the 100 Hall's Facility's Controlled Drug Audit form, dated February 2014, which indicated, "...Control drugs are counted at each shift by two members of the nursing staff, the nurse/medication aide coming on duty and the nurse/medication aide going off duty. Signatures by the nurse/medication aides verify that an actual count has been made and the count is the same as that indicated on the individual control drug record...."</p>			

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	<p>On 2/24/14 at 4:24 p.m. the DON provided a policy from contracted Pharmacy Long term Care Pharmacy Policy and Procedure Manual, with revision date of 7/2011, which indicated, "...Controlled Medications: All narcotics must be accounted for. The nurse will document the following on the corresponding narcotic control log: Date, Time, Quantity of medication released to the resident., The direction for use., Who received the medication...."</p> <p>3.1-50(a)(1)</p>			