

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2016
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NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00191479.</p> <p>Complaint IN00191479–Substantiated, no deficiencies related to the allegations were cited.</p> <p>Unrelated findings were cited at F–223, F–225 and F–226.</p> <p>Survey Dates: January 26 & 27, 2016</p> <p>Facility number: 000215 Provider number: 155322 AIM number: 100267600</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor type: Medicare: 1 Medicaid: 43 Other: 13 Total: 57</p> <p>Sample: 3</p> <p>These deficiencies also reflects state findings in accordance with</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0223 SS=E Bldg. 00	<p>410 IAC 16.2-3.1.</p> <p>QR completed on January 29, 2016 by 17934.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and review of facility documents, the facility failed to ensure there was no misappropriation of resident medication for 6 of 57 residents who resided in the facility. (Residents B, C, D, E, F, H)</p> <p>Findings include:</p> <p>On 1/28/16 at 1:50 p.m. interview with the Director of Nursing (DON), Administrator and Staff Development Nurse indicated the facility had missing medications. The DON indicated that on the morning of 1/19/16 she had</p>	F 0223	<p>F 223 <u>Corrective Action for Affected Residents:</u> All narcotics for the 6 residents affected were immediately reviewed. <u>Corrective Action for Potentially Affected Residents:</u> All residents receiving Narcotic medications have the potential to be affected. The medications are double locked at all times, counted/completed by incoming and outgoing nurses together for accountability and key is secured by Nurse in Charge for accountability and accuracy of administration and counting of medications. Missing medications replaced accordingly. Residents received all medication as ordered no missed doses</p>	02/26/2016

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	<p>received a call from nurse #1 who indicated resident (B) had a missing medication card of 60 Tramadol tablets (pain medication). Review of the order for resident (B) indicated an order for Tramadol HCL 50 milligrams three times daily. Further interview with nurse #1 indicated the card and sign-out sheet were both missing. Nurse #1 had done the shift narcotic count with the third shift nurse, and indicated the count was correct but she knew the resident had previously had a full card of Tramadol. The Staff Development nurse was informed of the missing card and searched all medication carts and medication room without finding the medication. The Staff Development nurse called the pharmacy and was told it would be hard to track the missing medication as the medication and sign out sheet were both missing. The Staff Development Nurse sent a text message to the Administrator and the DON who were out of town, of the missing medication.</p> <p>On 1/21/16 in the a.m. the night and day shift nurses were doing the narcotic count and noted resident (C) did not have his Ativan</p>		<p>occurred. <u>Measures for Prevention:</u> In addition to current measures, a new narcotic sheet for shift change has been implemented to include the number of cards of medications counted and any reason for a change in number. DON to be notified immediately of any discrepancies observed during the Narcotic count. Narcotics to be destroyed by DON or Designee and witnessed by two nurses. A lock box will be placed in Med Room to dispose of discontinued or expired Narcotics for DON to destroy and only DON or designee will have access to key. Nurse involved with the diversion of Narcotics was terminated and reported to Local authorities and Indiana Board of Nursing. <u>QA for Prevention:</u> New Narcotic count sheet for shift change to be turned in to DON Mail box weekly for Review. Locked box in med room to be checked by DON/designee on a daily basis to check for Narcotics that need to be destroyed. Inservice staff on new process. Review and Report monthly and add to the QA process indefinitely. Systemic changes to be completed by 02/26/2015.</p>		

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	<p>(schedule four medication for anxiety). The nurses asked the Staff Development Nurse if she had taken the resident's medication. Interview with the Staff Development Nurse indicated resident (C) had Ativan missing and also the count sheet was missing. Review of the order for resident (C) indicated Ativan 1 milligram one hour prior to showers. Further interview indicated staff thought 14 Ativan were missing.</p> <p>On 1/21/16 at approximately 7:00 a.m. the Staff Development Nurse asked the maintenance man to assist her while they searched the bio-hazard box. She indicated she wanted a staff person to witness her search. The search of the box found a torn "Controlled drug record" for resident (D) for Fentanyl (narcotic pain medication)25 micrograms every 3 days. She indicated the form had been written on as discontinued on 1/11/16 but indicated she and the DON are the nurses who destroy narcotics and they had never received the 2 Fentanyl patches to destroy.</p> <p>Also found in the bio-hazard box</p>			

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	<p>on 1/21/16 was a "torn" "Controlled Drug Record" for resident (E) for Hydrocodone (narcotic pain medication) 7.5-325 one per mouth every eight hours as needed. The record had been written on as being discontinued on 1/13/16 but again the Staff Development nurse and DON had never received the medication to destroy which was listed as 44 tabs.</p> <p>On 1/23/16 at 11:30 p.m. the DON received a text message from nurse #3, who is a third shift nurse. The message stated resident (D) and resident (E) had Fentanyl patches on that were dated 1/21/16 and they were scheduled to be changed on 1/24/16. The message indicated nurse #4 had signed out the patches on 1/23/16 at 4:00 p.m. and the count was correct but the date on the patches for residents (D) and (E) was 1/21/16.</p> <p>Further interview with the DON indicated the rest of the text message came through on 1/24/16 at 7:22 a.m. from nurse #3, who stated resident (F) had an order for as needed Vicodin (narcotic pain</p>			

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	<p>medication) and it was given three times on 1/13/16 . Nurse #3 stated this was unusual for resident (F) to take that many in one day. She indicated nurse #4 had signed the count book for the Vicodin at 4:00 p.m. on 1/23/16 but had not signed the "medication administration record" as given.</p> <p>On 1/24/16 the DON received a call from nurse #5 who indicated resident (H) had an order for Vicodin to be given at 8:00 a.m., 2:00 p.m., 8:00 p.m. and 2:00 a.m. Nurse #5 indicated nurse #4 had documented giving the resident Vicodin at 8:00 a.m., 11:00 a.m. and 3:00 p.m.</p> <p>Interview with the DON on 1/28/16 at 1:50 p.m. indicated nurse #3 stated she checked the Fentanyl patches for residents (D), (E) and (G) on 1/24/16 at 6:00 p.m. and noticed the patches had been moved on the residents and now were dated 1/24/16 but looked "dry". On 1/25/16 in the a.m. the DON, Staff Development Nurse and nurse #1 went to observe the patches on the above 3 residents and indicated they were "dry". Further interview with the DON indicated staff place the Fentanyl</p>			

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F 0225 SS=E Bldg. 00	<p>patches on residents, apply tegaderm over them and date them. The DON indicated she removed the patches for all 3 residents and applied new patches at that time. She indicated Nurse #4 was asked to provide a statement on these discrepancies but Nurse #4 resigned without notice and left the facility before providing any information.</p> <p>3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other</p>				

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	<p>officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and review of facility documents, the facility failed to follow their policy and procedure for reporting timely to the Indiana State Department of Health missing narcotic medications for 6 of 57 residents who resided in the facility. (Residents B, C, D, E, F, H)</p> <p>Finding includes:</p> <p>On 1/28/16 at 1:50 p.m. interview with the Director of Nursing (DON), Administrator and Staff Development Nurse indicated the facility had missing medications. The DON indicated that on the morning of 1/19/16 she had</p>	F 0225	<p>F225 <u>Corrective Action for Affected Residents:</u> Report immediately to ISDH and initiate internal investigation. <u>Corrective Action for Potentially Affected Residents:</u> All residents have the potential to be affected. Facility will report immediately any alleged violations including misappropriation of property, abuse, neglect and injuries of unknown source, to the administrator to be reported accordingly to ISDH. <u>Measures for Prevention:</u> Will continue to In-Service all staff about Abuse, Neglect, misappropriation of property, injuries of unknown source, according to ISDH and facility protocol to assure everybody is aware that any of the above allegations need to be reported immediately to the</p>	02/26/2016

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	<p>received a call from nurse #1 who indicated resident (B) had a missing medication card of 60 Tramadol tablets. Review of the order for resident (B) indicated he had an order for Tramadol HCL 50 milligrams three times daily. Further interview with nurse #1 indicated the card and sign-out sheet were both missing. Nurse #1 had done the shift narcotic count with the third shift nurse, and indicated the count was correct but she knew the resident had previously had a full card of Tramadol.</p> <p>On 1/21/16 in the a.m. the night and day shift nurses were doing the narcotic count and noted resident (C) did not have his Ativan. The nurses asked the Staff Development Nurse if she had taken the resident's medication. Interview with the Staff Development Nurse indicated resident (C) had Ativan missing and also the count sheet was missing. Review of the order for resident (C) indicated Ativan 1 milligram one hour prior to showers. Further interview indicated staff thought 14 Ativan were missing.</p>		<p>Administrator or Designee. The facility will continue to screen all applicants by doing background checks, verifying appropriate credentials and checking that appropriate licensing agencies have no pending actions. <u>QA for Prevention</u>: Administrator and DON will review and discuss all incidents daily. Will Review weekly at IDT meeting and trends will be discussed at monthly QA. Will be added to the QA process indefinitely. Systemic changes to be completed by 02/26/2015.</p>	

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	<p>On 1/21/16 at approximately 7:00 a.m. the Staff Development Nurse asked the maintenance man to assist her while they searched the bio-hazard box. She indicated she wanted a staff person to witness her search. The search of the box found a torn "Controlled drug record" for resident (D) for Fentanyl 25 micrograms every 3 days. She indicated the form had been written on as discontinued on 1/11/16 but indicated she and the DON are the nurses who destroy narcotics and had never received the 2 Fentanyl patches to destroy.</p> <p>Also found in the bio-hazard box on 1/21/16 was a torn "Controlled Drug Record" for resident (E) for Hydrocodone 7.5-325 one per mouth every eight hours as needed. The record had been written on as being discontinued on 1/13/16 but again the Staff Development nurse and DON had never received the medication to destroy which was listed as 44 tabs.</p> <p>On 1/23/16 at 11:30 p.m. the DON received a text message from nurse #3, who is a third shift nurse. The message stated resident (D)</p>			

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	<p>and resident (E) had Fentanyl patches on that were dated 1/21/16 and they were scheduled to be changed on 1/24/16. The message indicated nurse #4 had signed out the patches on 1/23/16 at 4:00 p.m. and the count was correct but the date on the patches for residents (D) and (E) was 1/21/16.</p> <p>Further interview with the DON indicated the rest of the text message came through on 1/24/16 at 7:22 a.m. from nurse #3, who stated resident (F) had an order for as needed Vicodin and it was given three times on 1/13/16. Nurse #3 stated this was unusual for resident (F) to take that many in one day. She indicated nurse #4 had signed the count book for the Vicodin at 4:00 p.m. on 1/23/16 but had not signed the "medication administration record" as given.</p> <p>On 1/24/16 the DON received a call from nurse #5 who indicated resident (H) had an order for Vicodin to be given at 8:00 a.m., 2:00 p.m., 8:00 p.m. and 2:00 a.m. Nurse #5 indicated nurse #4 had documented giving the resident Vicodin at 8:00 a.m., 11:00 a.m. and 3:00 p.m.</p>			

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	<p>Interview with the DON on 1/28/16 at 1:50 p.m. indicated nurse #3 stated she checked the Fentanyl patches for residents (D), (E) and (G) on 1/24/16 at 6:00 p.m. and noticed the patches had been moved on the residents and now were dated 1/24/16 but looked "dry". On 1/25/16 in the a.m. the DON, Staff Development Nurse and nurse #1 went to observe the patches on the above 3 residents and indicated they were "dry". Further interview with the DON indicated staff place the Fentanyl patches on residents, apply tegaderm over them and date them. The DON indicated she removed the patches for all 3 residents and applied new patches at that time.</p> <p>Interview with the Administrator on 1/28/16 at 1:50 p.m. indicated she had not reported these incidents to the Indiana State Department of Health. She then indicated she would report it now.</p> <p>On 1/28/16 at 3:00 p.m. review of the current facility "Reportable Incidents Policy" dated 11/15/1997 and revised on 1/15/2013 indicated the following:</p>			

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F 0226 SS=E Bldg. 00	<p>"1. Reportable Incidents</p> <p>Facilities are required by law to report incidents within 24 hours of occurrence to the Long Term Care Division. CFR 483.13(c)(2) states:</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State Law through established procedures (including to the State Survey and Certification Agency)."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and review of facility documents, the facility</p>	F 0226	F226 <u>Corrective Action for Affected Residents:</u> Report	02/26/2016
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	<p>failed to implement their written policies and procedures for reporting misappropriation of resident property for 6 of 57 residents who resided in the facility. (Residents B, C, D, E, F ,H)</p> <p>Finding includes:</p> <p>On 1/28/16 at 1:50 p.m. interview with the Director of Nursing (DON), Administrator and Staff Development Nurse indicated the facility had missing medications. The DON indicated that on the morning of 1/19/16 she had received a call from nurse #1 who indicated resident (B) had a missing medication card of 60 Tramadol tablets. Review of the order for resident (B) indicated he had an order for Tramadol HCL 50 milligrams three times daily. Further interview with nurse #1 indicated the card and sign-out sheet were both missing. Nurse #1 had done the shift narcotic count with the third shift nurse, and indicated the count was correct but she knew the resident had previously had a full card of Tramadol. The Staff Development nurse was informed of the missing card and searched all medication</p>		<p>immediately to ISDH and initiated internal investigation. <u>Corrective Action for Potentially Affected Residents:</u> All residents have the potential to be affected. Facility will report immediately any alleged violations including misappropriation of property, abuse, neglect, and injuries of unknown source, to the administrator to be reported accordingly to ISDH. <u>Measures for Prevention:</u> Will Re-inservice all staff about Abuse, neglect, misappropriation of property, injuries of unknown source according to ISDH and facility protocol to assure everybody is aware that any of the above allegations need to be reported immediately to the Administrator or Designee. The facility will continue to screen all applicants by doing background checks, verifying appropriate credentials and checking that appropriate licensing agencies have no pending actions. <u>QA for Prevention:</u> Administrator and DON will review and discuss all incidents daily. Will Review weekly at IDT meeting and trends will be discussed at monthly QA. Will be added to the QA process indefinitely. Systemic changes to be completed by 02/26/2015.</p>	

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	<p>carts and medication room without finding the medication.</p> <p>On 1/21/16 in the a.m. the night and day shift nurses were doing the narcotic count and noted resident (C) did not have his Ativan. The nurses asked the Staff Development Nurse if she had taken the resident's medication. Interview with the Staff Development Nurse indicated resident (C) had Ativan missing and also the count sheet was missing. Review of the order for resident (C) indicated Ativan 1 milligram one hour prior to showers. Further interview indicated staff thought 14 Ativan were missing.</p> <p>On 1/21/16 at approximately 7:00 a.m. the Staff Development Nurse asked the maintenance man to assist her while they searched the bio-hazard box. She indicated she wanted a staff person to witness her search. The search of the box found a torn "Controlled drug record" for resident (D) for Fentanyl 25 micrograms every 3 days. She indicated the form had been written on as discontinued on 1/11/16 but indicated she and the DON are the nurses who destroy</p>			

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	<p>narcotics and had never received the 2 Fentanyl patches to destroy.</p> <p>Also found in the bio-hazard box on 1/21/16 was a "torn" "Controlled Drug Record" for resident (E) for Hydrocodone 7.5-325 one per mouth every eight hours as needed. The record had been written on as being discontinued on 1/13/16 but again the Staff Development nurse and DON had never received the medication to destroy which was listed as 44 tabs.</p> <p>On 1/23/16 at 11:30 p.m. the DON received a text message from nurse #3, who is a third shift nurse. The message stated resident (D) and resident (E) had Fentanyl patches on that were dated 1/21/16 and they were scheduled to be changed on 1/24/16. The message indicated nurse #4 had signed out the patches on 1/23/16 at 4:00 p.m. and the count was correct but the date on the patches for residents (D) and (E) was 1/21/16.</p> <p>Further interview with the DON indicated the rest of the text message came through on 1/24/16</p>				

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	<p>at 7:22 a.m. from nurse #3, who stated resident (F) had an order for as needed Vicodin and it was given three times on 1/13/16. Nurse #3 stated this was unusual for resident (F) to take that many in one day. She indicated nurse #4 had signed the count book for the Vicodin at 4:00 p.m. on 1/23/16 but had not signed the "medication administration record" as given.</p> <p>On 1/24/16 the DON received a call from nurse #5 who indicated resident (H) had an order for Vicodin to be given at 8:00 a.m., 2:00 p.m., 8:00 p.m. and 2:00 a.m. Nurse #5 indicated nurse #4 had documented giving the resident Vicodin at 8:00 a.m., 11:00 a.m. and 3:00 p.m.</p> <p>Interview with the DON on 1/28/16 at 1:50 p.m. indicated nurse #3 stated she checked the Fentanyl patches for residents (D), (E) and (G) on 1/24/16 at 6:00 p.m. and noticed the patches had been moved on the residents and now were dated 1/24/16 but looked "dry". On 1/25/16 in the a.m. the DON, Staff Development Nurse and nurse #1 went to observe the patches on the above 3 residents and indicated they were "dry".</p>				

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	<p>Further interview with the DON indicated staff place the Fentanyl patches on residents, apply tegaderm over them and date them. The DON indicated she removed the patches for all 3 residents and applied new patches at that time.</p> <p>Interview with the Administrator on 1/28/16 at 1:50 p.m. indicated she had not reported these incidents to the Indiana State Department of Health. She then indicated she would report it now.</p> <p>On 1/28/16 at 3:00 p.m. review of the current facility "Reportable Incidents Policy" dated 11/15/1997 and revised on 1/15/2013 indicated the following:</p> <p>"1. Reportable Incidents</p> <p>Facilities are required by law to report incidents within 24 hours of occurrence to the Long Term Care Division. CFR 483.13(c)(2) states:</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported</p>			

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	<p>immediately to the administrator of the facility and to other officials in accordance with State Law through established procedures (including to the State Survey and Certification Agency)."</p> <p>3.1-28(a)</p>				