

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/18/2016
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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00196840, IN00196987, and IN00197471.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and Licensure Survey completed on 2-22-2016.</p> <p>Complaint IN00196840-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00196987- Substantiated. Deficiencies related to the allegations are cited at F157, F282, and F309.</p> <p>Complaint IN00197471- Substantiated. Deficiency related to the allegations is cited at F353.</p> <p>Survey dates: April 15, and 18, 2016</p> <p>Facility number: 000476 Provider number: 155446 AIM number: 100290870</p> <p>Census bed type: SNF/NF: 88 Total: 88</p>	F 0000	<p>This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.</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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F 0157 SS=D Bldg. 00	<p>Census payor type: Medicare: 19 Medicaid: 56 Other: 13 Total: 88</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on April 20, 2016 by 17934.</p> <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</p>			

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	<p>discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review the facility failed to notify the physician of an unavailable medication to begin treatment for 1 of 3 residents reviewed with new treatments in a sample of 8. (Resident #Y)</p> <p>Findings include:</p> <p>Resident #Y's record was reviewed 4-15-2016 at 2:03 PM. Resident #Y's diagnoses included, but were not limited to, high blood pressure, end stage kidney disease, and anemia.</p> <p>A physician's order dated 3-24-2016 indicated to apply Silver Sulfadiazine cream every day shift and every night shift to a burn on Resident #Y's left hip.</p>	F 0157	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #Y's physician has been notified of the delay in treatment for Silver Sulfadiazine by nursing. (03/27/16) An order was obtained by nursing to discontinue the treatment as an alternate treatment was already ordered. How the facility will identify other residents having the potential to be affected by the same deficient practice; For other residents having the potential to be affected, a treatment audit was conducted by the	05/10/2016

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	<p>A review of Resident #Y's Treatment Administration Record dated March 2016 indicated the Silver Sulfadiazine cream was not available for Administration on 3-24 and 3-25-2016.</p> <p>On 3-25-2016 at 11:10 AM, the physician was notified the cream was not available for administration, delaying treatment of the burn for another day.</p> <p>In an interview on 4-18-2016 at 1:07 PM, the Director of Nursing indicated the physician should be notified if a medication is not available to begin treatment.</p> <p>This Federal tag is related to Complaint IN00197471.</p> <p>3.1-5(a)(3)</p>		<p>DON/Designee 04/28/16 and completed on 04/29/16, to ensure treatment supplies were available for ordered treatments, and that only one treatment order existed for each site/wound. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; Reeducation was initiated by the DSD on 4/26/16 with nurses covering: 1. Ensuring treatment supplies and/or meds are available for ordered treatments, and if not available the physician must be notified and an alternate treatment order obtained. 2. Ensuring one treatment order is in place per site/wound. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: An audit of medications not administered due to lack of medication availability via the med admin audit report, will be conducted by DON/designee 5 times per</p>		

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 follow physician's orders for treatments for 2 of 3 residents reviewed with treatment orders in a sample of 8. (Resident #Y and Resident #D)</p> <p>Findings include:</p> <p>1. Resident #Y's record was reviewed 4-15-2016 at 2:03 PM. Resident #Y's diagnoses included, but were not limited to, high blood pressure, end stage kidney disease, and anemia.</p> <p>A physician's order dated 4-11-2016 indicated to apply Xeroform gauze and a</p>	F 0282	<p>week x's 2 weeks, 3 times per week x's 2 weeks, weekly for 8 weeks, then monthly for 3 months. Negative findings will be corrected immediately and reviewed monthly in the QA committee meeting times 6 months for further review and/or recommendations.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The MAR/TAR for Residents Y was reviewed by DON/Designee and a skin assessment was completed for Resident Y on 4/26/16 to identify all active wounds. The MAR/TAR for Residents D was reviewed by DON/Designee and a skin assessment was completed for Resident D on 4/24/16 to identify all active wounds. Physician</p>	05/10/2016

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	<p>dry dressing to Resident #Y's left lateral thigh every day shift.</p> <p>A review of Resident #Y's Treatment Administration Record (TAR) dated April 2016 indicated no documentation for the dates of 4-12 and 4-14.</p> <p>In an interview on 4-15-2016 at 10:09 AM, LPN #1 indicated there was not enough staff to complete treatments in a timely manner. If the documentation was not completed, then the treatment was not completed.</p> <p>In an interview on 4-18-2016 at 1:07 PM, the Director of Nursing (DON) indicated that although there was no specific policy for following physician orders, it was a nursing standard to follow physician orders. 2. A review of the MDS quarterly assessment completed on 2-10-2016 for Resident D, indicated the BIMS (Brief inventory of mental status) was 15/15, which indicated the resident was cognitively intact.</p> <p>A TAR (Treatment Administration Record) for Resident D for April 2016 was provided by the Director of Nursing (DON) on 4-18-2016 at 1:07 p.m.</p> <p>A review of the April TAR 2016 indicated the following:</p>		<p>was notified of current wounds and treatment orders were reconciled on 4/26/16 by DON/Designee. How the facility will identify other residents having the potential to be affected by the same deficient practice; An audit of residents with skin/wound issues was conducted by the DON/Designee on April 29, 2016 to identify documentation omissions on MARs/TARs. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; Nurses were reeducated by DON/Designee on 4/29/16 regarding following physicians orders and documentation of treatments. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: MAR/TARs will be audited for documentation omissions by DON/Designee 5 times per week x's 2 weeks, 3 times</p>		

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	<p>There were 5 orders for different wound sites dated 3-31-2016 to "monitor dressing every day to ensure adequate adhesion and to evaluate drainage or leakage; observe the area around the dressing for s/s (signs symptoms) of infections...every day shift..." The 5 sites to monitor included the left buttock distal, left buttock proximal, right buttock distal, right buttock, and the right thigh. The TAR indicated no documentation for wound care for the following April 2016 dates, the 1st, 3rd, 5th ,8th, 10th, 14th, 16th and 17th.</p> <p>There were 4 orders for treatments for the different wound sites dated 4-5-2016, to "...cleanse with Normal Saline, apply medihoney, apply bordered gauze every day shift every other day for wound...." The 4 sites for wound care included the left buttock distal, the left buttock proximal, the right buttock distal and the right buttock. The TAR indicated no documentation for wound care for the following April 2016 dates, the 8th,10th and 14th (a Friday, Sunday and a Thursday).</p> <p>There was an order for the right thigh wound dated 4-9-2016 to "...cleanse with normal saline, apply medihoney, apply foam dressing with tape every day shift</p>		<p>per week x's 2 weeks, weekly for 8 weeks, then monthly for 3 months. Negative findings will be corrected immediately and reviewed monthly in the QA committee meeting times 6 months for further review and/or recommendations.</p>	

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F 0309 SS=D	<p>every other day for wound..." The TAR was initialed on 4-12-2016 (a Tuesday), but documentation for care was done on the 10th (Sunday) or the 14th (Thursday).</p> <p>An interview with LPN #20 on 4-18-2016 at 2:12 p.m., indicated if the treatments were not documented on the TAR, it would look like the wound care was not done. The LPN indicated Resident D went to dialysis on Tuesdays, Thursdays and Saturdays at 10:30 a.m., and if the dressings were not changed prior to the resident leaving, then the day shift would not have documented on the TAR that the dressings were changed.</p> <p>An interview with the West hall Unit Manager on 4-18-2016 at 2:16 p.m., indicated the dressing times for Resident #D were changed to the night shift due to day shift being too busy to get the dressings changed prior to dialysis.</p> <p>This Federal Tag is related to Complaint IN00197471.</p> <p>3.1-35(g)(2)</p>			
	483.25 PROVIDE CARE/SERVICES FOR			

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Bldg. 00	<p>HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to begin treatment for a burn in a timely manner for 1 of 3 residents reviewed with new treatments in a sample of 8. (Resident #Y)</p> <p>Findings include:</p> <p>Resident #Y's record was reviewed 4-15-2016 at 2:03 PM. Resident #Y's diagnoses included, but were not limited to, high blood pressure, end stage kidney disease, and anemia.</p> <p>In an interview on 4-15-2016 at 1:57 PM, Resident #Y indicated he had spilled coffee on himself during transport to dialysis. Although Resident #Y indicated he had given information to the transport driver and to the dialysis unit, neither assessed the area. Resident #Y further indicated on his return to the facility, he was in a hurry to see his girlfriend, and refused to allow the nurse to do a post dialysis skin assessment.</p>	F 0309	<p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician was notified that Silvadene/treatment was not available for Residents #Y on 3/27/16 by nursing. An order was obtained by nursing to discontinue treatment as an alternate treatment was already ordered. How the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was conducted by the DON/Designee beginning 4/28/16 of medications/treatments documented as "not administered" and physician notification. Alternate orders were obtained as physician deemed appropriate. What</p>	05/10/2016

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	<p>In an interview on 4-18-2016 at 9:33 AM, LPN #2 indicated she was informed by the CNA at 5:30 AM on 3-24-2016 of the burn on Resident #Y's left hip. LPN #2 then indicated she measured the area, and described the area as having intact skin with blisters. Further, LPN #2 indicated she notified the physician and received orders for the Silvadene cream.</p> <p>A physician's order dated 3-24-2016 indicated to apply Silver Sulfadiazine cream every day shift and every night shift to a burn on Resident #Y's left hip.</p> <p>A review of Resident #Y's Treatment Administration Record dated March 2016 indicated the Silver Sulfadiazine cream was not available for Administration on 3-24 and 3-25-2016.</p> <p>On 3-25-2016 at 11:10 AM, the physician was notified the cream was not available for administration, delaying treatment of the burn for another day.</p> <p>In an interview on 4-18-2016 at 1:07 PM, the Director of Nursing indicated the physician should have been notified the medication was not available so orders could have been obtained to begin treatment.</p> <p>This Federal tag is related to Complaint</p>		<p>measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; Reeducation was initiated by the DSD on 4/26/16 covering the proper process to follow when medication is not available including physician notification, obtaining an alternate treatment when needed, and timely administration of medications/treatments. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: and An audit of treatments not administered will be conducted by unit managers/designee to ensure treatments are performed/documented timely 5 times per week x's 2 weeks, 3 times per week x's 2 weeks, weekly for 8 weeks, then monthly for 3 months. Negative findings will be corrected immediately and renewed monthly in QAA committee meeting times 6 months for</p>	

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F 0353 SS=E Bldg. 00	<p>IN00197471.</p> <p>3.1-37(a)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate staff to ensure medications and treatments were administered in a timely manner for 3 of 4 residents reviewed with medications and treatments in a sample</p>	F 0353	<p>further review and/or recommendations</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician was notified of late medication administration omissions in</p>	05/10/2016	

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	<p>of 8. This had the potential to affect all dependent residents residing in the facility. (Resident #D, Resident #E, and Resident #F)</p> <p>Findings include:</p> <p>1. During medication pass observation on 4-15-2016 at 10:47 AM, Resident #E received the following: Ferrous Sulfate 325 mg tablet scheduled for 9:00 AM, and Proazosin 5 mg tablet scheduled for 8:00 AM.</p> <p>Resident #E's record was reviewed 4-18-2016 at 8:41 AM. Resident #E's diagnoses included, but were not limited to, high blood pressure, diabetes, and heart failure.</p> <p>A review of Resident #E's physician's orders indicated Resident #E was to receive Ferrous Sulfate 325 mg three times per day at 9 AM, 1 PM, and 5 PM. Further, Resident #E was to receive Proazosin 5 mg every 8 hours at midnight, 8 AM, and 4 PM.</p> <p>In an interview on 4-15-2016 at 11:27 AM, Resident #E indicated medications were not given according to any sort of schedule, but when the nurses could get around to it as there were not enough nurses to assure medications were given</p>		<p>MAR/TAR documentation for Residents E, and F on 5/2/16. How the facility will identify other residents having the potential to be affected by the same deficient practice; Staffing levels were reviewed by the Administrator and Nursing Administration on 4/18/16 to ensure sufficient staff to meet the needs of residents. Resident Council and Complaint/Grievances Processes will be used each month to identify residents potentially impacted by staffing concerns, with remediation facilitated as indicated. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur; MARs/TARs of residents will be reviewed by DON/designee to evaluate timing concerns and create optimal shift efficiencies with medication and treatment administration; changes will be made as deemed appropriate by</p>	

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	<p>on a routine basis.</p> <p>2. During medication pass observation on 4-15-2016 at 10:17 AM, Resident #F received the following: Methadone 10 mg scheduled for 9 AM, Gabapentin 300 mg scheduled for 9 AM, and Ipratropium/ Albuterol solution for nebulizer scheduled for 8 AM.</p> <p>Resident #F's record was reviewed 4-18-2016 at 8:52 AM. Resident #F's diagnoses included, but were not limited to, high blood pressure, diabetes, and depression.</p> <p>A review of Resident #F's physician's orders indicated Resident #F was to receive Methadone 10 mg every 12 hours at 9 AM, and 9 PM; Gabapentin 300 mg three times per day at 9 AM, 1 PM and 5 PM; and Ipratropium/ Albuterol solution as a nebulized dose every 4 hours at midnight, 4 AM, 8 AM, Noon, 4 PM, and 8 PM.</p> <p>In an interview on 4-15-2016 at 11:25 AM, Resident #F indicated his medications, especially his nebulizer were always late as there were not enough nurses to ensure medications were received at the right times.</p> <p>In a confidential interview on 4-15-2016</p>		<p>physicians. Administrator and DON met on 5/2/16 to review number of residents per unit with number of staff allocated to each unit per shift. Staffing/schedule was revised and staff reallocated to ensure sufficient staff to meet needs of the residents.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Random Resident and staff member interviews will be completed 3 times per week x's 4 weeks, weekly for 8 weeks, then monthly for 3 months. Administrator/Designee will discuss daily staffing needs in stand up meeting Monday through Friday to ensure sufficient staff to meet the needs of the residents. Scheduler/DSD will notify Administrator on weekends of staffing concerns for appropriate follow up. Staffing concerns identified through Resident Council, complaint/grievance processes, &/or random</p>	

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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804		
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	<p>at 10:37 AM, Nurse #3 indicated there was not enough staff to complete med pass in a timely manner as medications were scheduled for a multitude of times for one resident. Further, Nurse #3 indicated she had requested help to complete the med pass in a timely manner, but none was given.</p> <p>3. A confidential interview with a Resident with a BIMS (Brief Interview for Mental Status, to indicate cognitive level) score of 15/15 (cognitively intact), indicated the following: the Resident had to wait 2 hours for the call light to be answered to be assisted to re-position.</p> <p>4. An interview with Resident D on 4-18-2016 at 10:25 a.m., indicated the facility was understaffed. Resident D indicated the little things get over looked and the staff were ready to "drop". Resident D indicated the medications were not on time and the dressings for wounds were not getting done. Resident D indicated it was over a week without dressing changes or medication on the wounds.</p> <p>A review of the MDS quarterly assessment completed on 2-10-2016 for Resident D, indicated the BIMS was 15/15, which indicated the resident was cognitively intact.</p>		interviews will be presented to monthly QA times 6 months for further review and/or recommendations.		

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	<p>A TAR (Treatment Administration Record) for Resident D for April 2016 was provided by the Director of Nursing (DON) on 4-18-2016 at 1:07 p.m.</p> <p>A review of the April TAR 2016 indicated the following:</p> <p>There were 5 orders for different wound sites dated 3-31-2016 to "monitor dressing every day to ensure adequate adhesion and to evaluate drainage or leakage; observe the area around the dressing for s/s (signs symptoms) of infections...every day shift..." The 5 sites to monitor included the left buttock distal, left buttock proximal, right buttock distal, right buttock, and the right thigh. The TAR indicated no documentation for wound care for the following April 2016 dates, the 1st, 3rd, 5th, 8th, 10th, 14th, 16th and 17th.</p> <p>There were 4 orders for treatments for the different wound sites dated 4-5-2016, to "...cleanse with Normal Saline, apply medihoney, apply bordered gauze every day shift every other day for wound..." The 4 sites for wound care included the left buttock distal, the left buttock proximal, the right buttock distal and the right buttock. The TAR indicated no documentation for wound care for the</p>			
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	<p>following April 2016 dates, the 8th, 10th and 14th (a Friday, Sunday and a Thursday).</p> <p>There was an order for the right thigh wound dated 4-9-2016 to "...cleanse with normal saline, apply medihoney, apply foam dressing with tape every day shift every other day for wound..." The TAR was initialed on 4-12-2016 (a Tuesday), but documentation for care was done on the 10th (Sunday) or the 14th (Thursday).</p> <p>An interview with LPN #20 on 4-18-2016 at 2:12 p.m., indicated if the treatments were not documented on the TAR, it would look like the wound care was not done. The LPN indicated Resident D went to dialysis on Tuesdays, Thursdays and Saturdays at 10:30 a.m., and if the dressings were not changed prior to the resident leaving, then the day shift would not have documented on the TAR that the dressings were changed.</p> <p>An interview with the West hall Unit Manager on 4-18-2016 at 2:16 p.m., indicated the dressing times for Resident #D were changed to the night shift due to day shift being too busy to get the dressings changed prior to dialysis.</p> <p>This Federal tag is related to Complaint IN00197471.</p>			

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