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 10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
F0000	This visit was for the Recertification and state Licensure Survey. Survey dates: October 23, 24, 25, 26, 29, 2012 Facility number: 000215 Provider number: 155322 AIM number: 100267600 Survey team: Tim Long, RN-TC Christine Fodrea, RN Julie Wagoner, RN Census bed type: NF: 55 SNF/NF: 26 Total: 81 Census Payor type: Medicare: 5 Medicaid: 61 Other: 15 Total: 81 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 11/8/12 Cathy Emswiller RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
F0225 SS=D	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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. Based on interview and record review	F0225	**CORRECTIVE ACTION FOR**	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	the facility failed to report 1 of 2 allegations of potential abuse involving Resident #25 to the proper authorities in a timely manner. **Finding includes:** 1. Review, on 10/25/12 at 2:05 P.M., of an investigation of an allegation of neglect and verbal abuse made by Resident #25, indicated the allegation was not reported to ISDH and other proper authorities. The allegation was dated 09/28/12 at 1:30 P.M. The documentation indicated Resident #25 was yelling, upset, and indicated a CNA was "snotty", refused to get her up timely for an activity, and was "mean" to her. An interview with the Director of Nursing on 10/25/12 at 2:15 P.M., indicated this was not considered abuse because the resident still got to Bingo on time, just now an hour early like she preferred and the resident misinterpreted what the CNA had said and there had been a communication gap between the two. No verbal abuse could be substantiated. On 10/29/12 at 12:40 P.M., just prior to the final exit conference with the facility, the Director of Nursing indicated the allegation of neglect		**AFFECTED RESIDENTS** Resident # 6 is not identified on the "Stage 2 Sample Resident List" provided to Renaissance Village during the Exit Conference on 10/29/12 [See Attachment A]. Resident # 25 is incorrectly identified on the 2567 as having made an allegation of neglect. Renaissance Village requests IDR (Interdisciplinary Review) for Federal Tag F 225. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *Renaissance Village reports and will continue to report abuse according to ISDH guidelines and the facility's policy for Abuse Prevention.* ***MEASURES FOR PREVENTION*** The Administrator and Director of Nursing will investigate, review, discuss and report all allegations of potential alleged abuse according to ISDH policy guidelines. **QA FOR PREVENTION** All reported incidents of potential alleged abuse will be reviewed and discussed each month at the QA meeting. **EFFECTIVE DATE** The changes are completed and effective by November 28, 2012.	

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	made by Resident #25 was not reported because it was "felt this (the allegation/incident) was comparable to Resident Council concerns voiced regarding call lights not being answered timely. Timeliness of call light concerns are investigated in all Long Term Care facilities, though it is the understanding of (Facility's name) call light concerns are not routinely reported to ISDH as an allegation of abuse/neglect." When queried as to the allegation of the alleged CNA being "mean" and "nasty" to Resident #25, the Director of Nursing shrugged her shoulders and indicated she was just presenting the afore mentioned explanation as to why the facility did not report either allegation. 3.1-28(c)			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
F0226 SS=D	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 record review the facility failed to report 1 of 2 (#25) allegations of potential abuse to the proper authorities in a timely manner. Findings include: 1. Review, on 10/25/12 at 2:05 P.M., of an investigation of an allegation of neglect and verbal abuse made by Resident #25, indicated the allegation was not reported. The allegation was dated 09/28/12 at 1:30 P.M. The documentation indicated Resident #25 was yelling, upset, and indicated a CNA was "snotty", refused to get her up timely for an activity, and was "mean" to her. Interview with the Director of Nursing indicated this was not considered abuse because the resident still got to Bingo on time, just now an hour early like she preferred and the resident misinterpreted what the CNA had said and there had been a communication gap between the two. No verbal abuse could be substantiated.	F0226	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** Renaissance Village [R.V.]reports misappropriation of resident funds as defined in the ISDH policy "…MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY...The report must be submitted within 24 hours after the preliminary investigation has determined that resident property or funds have been misappropriated." Resident # 6 is not identified on the "Stage 2 Sample Resident List" provided to Renaissance Village during the Exit Conference on 10/29/12. Resident # 25 is incorrectly identified on the 2567 as having made an allegation of neglect. Regarding the based on statement "The facility also failed to report the allegations of abuse in a timely manner." The incidents reviewed by the ISDH survey team were indeed reported to the administrator immediately. Renaissance Village requests IDR (Interdisciplinary Review) for Federal Tag F 226. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *All*	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	On 10/29/12 at 12:40 P.M., just prior to the final exit conference with the facility, the Director of Nursing indicated the allegation of neglect made by Resident #25 was not reported because it was "felt this (the allegation/incident) was comparable to Resident Council concerns voiced regarding call lights not being answered timely. Timeliness of call light concerns are investigated in all Long Term Care facilities, though it is the understanding of (Facility's name) call light concerns are not routinely reported to ISDH as an allegation of abuse/neglect." When queried as to the allegation of the alleged CNA being "mean" and "nasty" to Resident #25, the Director of Nursing shrugged her shoulders and indicated she was just presenting the afore mentioned explanation as to why the facility did not report either allegation. 3.1-28(a)		*allegations of potential alleged abuse are investigated, reviewed, discussed and reported to the administrator immediately.* ***MEASURES FOR PREVENTION*** All facility staff were re-educated on the facilities abuse prevention policy. **QA FOR PREVENTION** The facility Administrator or designee will interview three staff members monthly and report to the findings at the monthly QA meeting [See Attachment B]. **EFFECTIVE DATE** The changes are completed and effective by November 28, 2012. Response to letter dated 11/28/2012 addendum F225. F226 In all abuse allegations or situations, the Administrator must be contacted immediately. An Incident Report is to be filled out using standard nursing protocols for each resident involved. Documentation shall be gathered regarding the incident. As soon as possible, within 24 hours, the Administrator/D.O.N. or designee(s) will notify and send the appropriate written documentation to the appropriate agencies, including but not limited to the following: A. Indiana State Department of Health B. Adult Protective Services C. Area Ombudsman D. Health Professions Service Bureau (if applicable) E. County Law Enforcement (if applicable) Sheriff's Office and/or Prosecuting Attorney Note: The Administrator/D.O.N.	

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 10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
			or designess(s) will determine if Health Professions Service Bureau and/or county lalw enforcement officials are to be notified. Per Nursing Policy for contusions and lacerations, if the individual measurements are 10cms or greater and of unknow origin, notify the D.O.N., A.D.O.N. or on-call nurse immediately, as this requires ISDH, APS and Ombudsman notification.	

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 10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
F0272 SS=A	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on record review and interview the facility failed to ensure a bladder incontinence assessment was accurate for 1 of 3 residents (#79) reviewed for bladder incontinence.	F0272	**CORRECTIVE ACTION FOR AFFECTED RESIDENT** The inaccurate bladder assessment documentation for Resident # 79 was addressed with the affected staff.	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	Finding includes: The clinical record for Resident #79 was reviewed 10/25/12 at 10:30 A.M. The resident was admitted to facility on 10/15/10 with diagnoses, including but not limited to Alzheimer's disease, hypertension, hyperlipidemia, history of tobacco use, history of depression, postmenopausal, anxiety, osteoporosis, osteoarthritis, history of suicidal ideation, rectocele. Review of nursing progress notes, from 04/2012 - 10/2012 documented the resident was continent of her bladder and toileted herself. Short term memory issues were also documented. The toileting flow record for October 2012 indicated the resident was on a prompt/cue program - to be prompted upon rising, before and after meals, at bedtime, and as needed through the night. The resident also was documented as using briefs. In addition it appeared the resident had about 1 incontinent episode documented daily from 6 am - 10 am. and was occasionally incontinent from 10 am - 2 PM. The MDS (Minimum Data Set) annual		**IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *A new bladder assessment form was developed and staff was educated on proper documentation.* ***MEASURES FOR PREVENTION*** The MDS Coordinator will review and log bladder assessment documentation for accuracy. [See attachment C] **QA FOR PREVENTION** The Director of Nursing or designee will monitor the results of the "prevention monitoring" for compliance and report monthly to QA. **EFFECTIVE DATE** The changes are completed and effective by November 28, 2012. Response to letter dated 11/28/2012 addendum F272 New assessment for Resident #79 completed as of 12/3/12. All residents will be reviewed with all comprehensive assessments usin g the new Bowel and Bladder Assessment form which was initiated and all staff in-serviced on its use. The M.D.S. coordinator reviews all voiding patterns bladder assessemts for accuracy.	

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	assessment, completed on 09/13/12, indicated the resident had exhibited a Brief Interview of Mental Status (BIMS)Score of 07, which demonstrated moderate dementia issues, required supervision only for transferring, walking, and toileting needs, and was occasionally incontinent (1 - 6 times in a 10 day observation period), and was on a trial of a toileting program, However, the bladder incontinence assessment, dated 09/07/12, indicated the resident had complete control of her bladder. The assessment indicated the resident was on a prompted voiding et cueing program. Interview with MDS coordinator, RN #20, on 10/29/12 at 10:10 A.M. indicated the nurses complete the bowel and bladder assessments and they do not always get the assessments as accurate as possible. 3.1-31(c)(3)			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, record review and interview, the facility failed to ensure proper health care plans for: 1 of 3 residents (#70) reviewed for behavior; and 1 of 3 residents (#18) reviewed for insomnia. Findings include: 1. Review of resident #18's clinical record on 10/26/12 at 10:30 A.M. indicated the resident had diagnoses including, but not limited to, insomnia, dementia (Alzheimer's type) and anxiety.	F0279	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** Resident # 18 currently has a care plan developed and in use for her Ambien she receives PRN [as needed] for insomnia. Resident # 70 currently has care plans developed and in use for her Xanax and Ambien. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** All Residents with a physician's order for PRN psychotropic medications will be reviewed for a Comprehensive Care Plan to address their inclusion of non-pharmacological	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	Review of the resident's Physician's Orders dated 9/26/12 indicated the resident has an order for Ambien CR 6.25 mg at bedtime PRN insomnia dated 9/7/12. Review of resident #18's MAR indicated use of Ambien 6.25 mg PRN on 9/9/12, 9/10/12; 9/11/12; 9/12/12; 9/13/12. The MAR does not indicate any non-pharmacological interventions attempted before administration of the PRN Ambien for insomnia on those dates. Review of the resident's nurse's notes on 9/9/12, 9/10/12; 9/11/12; 9/12/12; 9/13/12 did not indicate any non-pharmacological interventions attempted before use of Ambien PRN for insomnia on those dates. Review of the resident's health care plans did not indicate specific care plan for the use of Ambien PRN for insomnia. A care plan for mood/behaviors related to a diagnosis of dementia with depression had Ambien added on 9/10/12. The Ambien did not indicate what it's use was for and the care plan did not address insomnia. An interview with the (Director of		interventions. **MEASURES FOR PREVENTION** *The Unit Supervisors and Social Service staff will develop a Comprehensive Care Plan, addressing the use of non-pharmacological interventions, with all Residents having an order for a PRN [as needed] psychotropic medication.* ***QA FOR PREVENTION*** *The Director of Social Service will review 10 Care Plans for non-pharmacological interventions weekly times four [4], then monthly for residents receiving a PRN [as needed] psychotropic medication and report findings monthly at QA meeting [See Attachment D].* ***EFFECTIVE DATE*** *The changes are completed and effective by November 28, 2012. Response to letter dated 11/28/2012 addendum F279 Unit supervisors and social services were in-serviced on developing a comprehensive care plan addressing non-pharmacological interventions for PRN psychotropic medication.*	

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	Nursing) DN on 10/29/12 at 10:45 A.M. indicated the care plan for depression had Ambien added to it on 9/10/12. The DN indicated the care plan does not have interventions or approaches to try before use of the PRN Ambien. 2. The clinical record for Resident #70 was reviewed on 10/25/12 at 11:00 A.M. Resident #70 was admitted to the facility on 06/14/12. The resident's diagnosis, included but were not limited to blindness, insomnia, and diabetes. The admission Minimum Data Set (MDS) assessment, completed on 06/22/12, indicated the resident had not exhibited any physically abuse type behaviors. However, the Quarterly MDS assessment, completed on 09/21/12, indicated the resident had exhibited any physical abusive behaviors. Nursing progress notes reviewed from the Resident's admission to the facility on 06/13/12 to the present indicated on 10/15/12, resident sat on resident's bed and tried to get help with getting to the bathroom. Other notes indicated the resident needed help due to blindness but was sometimes impatient and non-compliant.			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	The facility Psychiatrist saw the resident on 06/30/12 and indicated she had anxiety related to the new facility and blindness. The Psychiatrist only suggested PRN (as needed) Xanax, an antianxiety medication, if needed. The resident was already receiving Ambien, a hypnotic, for insomnia Social service notes only indicated one documented behavior, dated 09/20/12, which indicated the resident was yelling at staff and tapping them on the face even after asked to stop. Social service 1:1 notes, reviewed from Admission through the present, indicated the resident isolated herself due to blindness and had worried some about her son but no behavior issues or big emotional issues were documented. The current health care plans for Resident #70, current through 01/04/2013, indicated no specific care plan for behavior management. There was a plan to address possible depressive mood disorders due to blindness and placement. The plan did not specify what the behaviors might be or what mood issues were actually to be monitored.			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	The same care plan was also copied and placed in a Behavior monitoring manual. The tracking for behaviors for Resident #70 indicated 1 -2 documented agitated type behaviors had occurred about once a month. Staff did not appear to be utilizing the interventions however interventions on the care plan were general, including monitor behaviors, notify social services, talk to the resident, psych services as needed. Other than talking to the resident, there were no immediate interventions staff could utilize if the resident was exhibiting a behavior. Interview with MDS coordinator , RN #20, on 10/29/12 at 11:15 A.M., confirmed the care plan was not very specific as to the behavior staff were to monitor and the interventions she indicated the plan "didn't tell what the behavior was that was to be tracked and the interventions were not specific for staff." 3.1-35(a)			

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 10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
F0282 SS=D	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.			
	Based on observation, interview and record review, the facility failed to ensure: 1 of 3 residents (#41) received assistance for shaving; 1 of 3 residents reviewed for behavior (resident #31) care plan was followed; 1 of 3 residents (#79)reviewed for urinary incontinence health care plan was followed regarding prompted toileting. Findings include: 1. Resident #31's clinical record was reviewed on 10/27/12 at 10:00 A.M.. The record indicated the resident had diagnoses including, but not limited to, anxiety, depression, insomnia and dementia, Alzheimer's type. Review of the physician's orders dated 9/28/12, indicated the resident had an order from 7/21/12 for Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) twice daily as needed (PRN) for agitation. Review of the resident's medication administration record for September	F0282	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** Resident # 31's Care Plan was updated to include the use of Ativan for failed non-pharmacological interventions. Staff were re-educated regarding documenting non-pharmacological interventions for the use of Ativan on resident # 31's PRN Psychotropic flow sheet in the MAR [See Attachment E]. Resident # 41 has a plan in place to address his need for shaving and staff have been re-educated to document any refusals. Staff were re-educated regarding the need to prompt Resident # 79 to void. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *Staff will be re-educated regarding supportive documentation required to show Care Plans are followed. Staff were further re-educated regarding the need to follow the Residents individualized care plans.* ***MEASURES FOR PREVENTION*** The Unit Supervisors will monitor 3 residents on their hall weekly times four [4], then monthly for	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	and October 2012 indicated the resident received PRN Lorazepam on 9/8/12 at 7:00 A.M. and 10/17/12 at 7:00 P.M.. The MAR did not indicate any interventions attempted before the administration of the PRN Lorazepam on 9/8/12 or 10/17/12. Review of the Mood/Behavior Monitoring Grid for September 2012 did not contain any mood or behavior incidents on 9/8/12. Review of the nurse's note's from 9/8/12 at 7:00 A.M. indicated the resident was "agitated, hollering, yelling at staff. Upset resident won't go to dining room. Given Ativan PRN. No documentation on non-pharmacological interventions were documented before administration of the PRN Ativan on 9/8/12. Review of the Mood/Behavior Monitoring Grid for October 2012 did not contain any mood or behavior incidents on 10/17/12. Review of the nurse's notes for 10/17/12 at 7:00 P.M. indicated resident is crying out, very agitated, crying "I don't know where anyone is" "I want my mom and dad". The nurse's note indicated the resident		compliance with following Care Plans and documentation of non-pharmacological interventions prior to use of psychotropic medications. **QA FOR PREVENTION** The Director of Nursing or designee will monitor the results of the "prevention monitoring" for compliance and report monthly to QA [See Attachment F p1; F p2; F p3] . **EFFECTIVE DATE** The changes are completed and effective by November 28, 2012. Response to letter dated 11/28/2012 addendum F282 All care plans for residents receiving PRN phychotropic medications were reviewed for non-pharmacological interventions and updated as necessary. All residents have the potential need to be shaved. Q.A. system put in place for unit supervisors to ensure residents are shaved timely. All residents on a prompted toileting plan have the potential need to ensure they are prompted and cued according to their individual plans. Unit supervisors are monitoring to ensure care plans followed.	

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	was medicated with PRN Ativan. The nurse's notes did not indicate any non-pharmacological interventions were attempted before administration of the PRN Ativan. Review of resident #31's health care plan initiated 2/14/11 and reviewed 9/12 indicated Problem/Need: resident has the potential for increased negative behaviors related to diagnosis of dementia and due to his confusion. Resident is being monitored for behaviors of being combative with staff, yelling, attempting to hit others, making verbal threats to staff, having intrusive wandering into other residents' rooms and being threatening towards staff when staff assist to redirect him. Resident has the potential for increased negative moods due to diagnosis of depression. The goal/outcome indicated the resident will accept staff redirection from negative moods and behaviors within 5-10 minutes of observed onset. Interventions included, but were not limited to: encourage participation in activities/events; enjoys talking about wife, children and grandchildren and wife can often assist with redirection over the phone if the resident is upset; use life review therapy as needed to engage including he			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	worked at Harvester, he has been married for over 63 years, he loves to talk about world war 2, he likes country music and he used to like using a metal detector; assess for signs and symptoms of infections. The health care plan did not indicate use of Ativan for agitation. Review of incidents requiring PRN Lorazepam on 9/8/12 and 10/17/12 did not indicate any non-pharmacological interventions for agitation or behavioral symptoms were attempted before administration of the medication. An interview with the director of nursing (DN) at 10:45 on 10/29/12 indicated the resident had a care plan for behaviors in the behavior monitoring book but the care plan was not followed. 2. On 10/24/12 at 1:45 P.M., Resident #41 was noted to be in his room in the wheelchair. The resident's face was noted to be unshaven. The resident's electric shaver was noted to be lying on top of the resident's personal refrigerator in his room. The top to the of the shaver was lying open. The resident indicated he could not put the shaver together and needed help to shave. He did not know why staff had not			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	assisted him to shave. On 10/26/12 at 9:51 A.M., Resident #41 was observed being pushed out of Exercise class. The Resident's face was unshaven and his t-shirt was noted to be too small for him and a little of his belly was exposed. On 10/26/12 at 1:30 P.M., Resident #41 was observed lying in bed asleep. The Resident's face was unshaven, and his electric razor/shaver was still lying on top of his refrigerator with the top open. On 10/29/12 at 8:45 A.M., Resident#41 was noted to be in bed awake, had just finished eating breakfast. His face had been shaved from last week. His razor was noted on his refrigerator but the top had been put together. The Resident said he did shave over the weekend. The last quarterly MDS, completed 10/16/12, indicated the resident required total staff assistance for personal hygiene and extensive assistance for dressing. The current health care plans for Resident #41, current through 01/13, indicated the following: : "Resident requires staff assist to complete his			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	ADL's, is confused at times requiring frequent cues to complete ADL tasks... Cognitive Loss - ...He requires cues/supervision r/t poor decisions r/t dietary choices and negative behaviors... Psychosocial - ...He needs total care re: ADL's and transfers. (Resident #41's name) continues to need encouragement from SS staff r/t his adjustment issues... ADL's - (Resident #41's name) will complete as much of his own care as he is able with staff assist as needed....monitor for any changes in dressing , bathing and grooming needs an assist as needed and/or encourage him to do as much as he is able..." Review of the behavior tracking for Resident #41 for October 2012 indicated the resident was being tracked for sexually inappropriate behaviors and wetting self. Review of nursing notes from 10/19/12 - 10/29/12, indicated there was no documentation of refusing to allow or do his facial grooming i.e. shaving. Review of social service notes, for October 2012, indicated there was no documentation about any issues with refusing to be shaved, ill fitting			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	clothes, or broken razor. Review of the ADL (Activities of Daily living) record for October 2012, indicated 10/08/12 was the last time resident #41 had been shaved. An interview with the MDS coordinator, RN #20 on 10/29/12 at 2:15 P.M., indicated sometimes the resident refused care, was usually unable to complete his ADL's by himself mostly due to lack of physical endurance due to heart issues. Interview with CNA #6, on 10/29/12 at 11:22 A.M., indicated the resident needed extensive ADL help in the mornings. She indicated the resident needed encouragement and help to shave. She indicated he might be able to shave his chin and a little bit of his face but would need help for most of his face. She also indicated the resident would need encouragement but was usually cooperative. She indicated he would not ask to be shaved but would cooperate with shaving with encouragement and help from staff. 3. The clinical record for Resident #79 was reviewed on 10/25/12 at 10:30 A.M. Resident #79 was admitted to facility on 10/15/10 with diagnoses, including but not limited to			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	Alzheimer's disease, hypertension, hyperlipidemia, history of tobacco use, history of depression, postmenopausal, anxiety, osteoporosis, osteoarthritis, history of suicidal ideation, rectocele. Nursing notes for the last 6 months (5/1/12 through 10/29/12) documented the resident as being continent of her bladder and toileting herself. The toileting flow record for October 2012 indicated the resident was on a prompt/cue program - to be prompted upon rising, before and after meals, at bedtime, and as needed through the night. The resident also was documented as using briefs. In addition it appeared the resident had about 1 incontinent episode documented daily from 6 am - 10 am. and was occasionally incontinent from 10 am - 2 PM. The MDS (Minimum Data Set) annual assessment, completed on 09/13/12, indicated the resident had exhibited a Brief Interview of Mental Status (BIMS) Score of 07, which demonstrated moderate dementia issues, required supervision only for transferring, walking, and toileting needs, and was occasionally			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	incontinent (1 - 6 times in a 10 day observation period), and was on a trial of a toileting program, However, the bladder incontinence assessment, dated 09/07/12, indicated the resident had complete control of her bladder. The assessment indicated the resident was on a prompted voiding et cueing program. The Health Care plans for Resident #79, last reviewed on 10/04/12, indicated a care plan for urine incontinence, initiated 10/21/10 , with interventions, including but not limited to, prompted toileting upon rising, before/after meals, at hs/prn approximately q 2 hours throughout night, wears briefs for comfort, On 10/25/12 at 11:08 A.M. , Resident #79 was observed seated on the side of her bed watching television. The resident was dressed, showed no visible signs of wetness. The resident's room was very malodorous. The resident's room was observed continuously from 11:08 A.M. - 11:53 A.M.. On 10/25/12 11:15 A.M., CNA #10 went into room to make sure Resident #79 was going to the dining room for lunch. CNA #10 then			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	proceeded to pass lunch trays to other resident. CNA #10 did not cue Resident #79 to go to the toilet. Hospice staff were noted to be in room visiting with Resident #79's roommate. At 11:53 A.M., Resident #79 was observed ambulating from her room to the dining room for the lunch meal. Observation, on 10/26/12 from 11:00 A.M. - 12:28 P.M., CNA #21 went into resident #79''s room, told her it was time for lunch, CNA #79 shut the bathroom door just before the resident walked by and out into the hall. CNA did not cue the resident to the bathroom at all. 3.1-35(g)(2)			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
F0311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.			
	Based on observation, record review and interview the facility failed to provide restorative program as designed, for 1 of 3 residents reviewed (Resident #89). Findings include: Resident #89's record was reviewed on 10-25-2012 at 10:55 AM. Resident #89's diagnoses included, but were not limited to depression, Parkinson's disease with dementia, and high blood pressure. A current physician's order summary dated 10-2012 indicated Resident #89's rehabilitation potential was fair. A Minimum Data Set (MDS) dated 8-02-2012 indicated Physical and Occupational therapy began 6-6-2012 and ended 7-31-2012 due to Resident #89 reaching full potential. The restorative communication form dated 7-31-2012 indicated Restorative therapy would be initiated and restorative program was to be	F0311	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** Resident # 89 was re-screened by the facility's therapy department and the restorative care plan updated and implemented. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** The therapy and/or restorative staff will work to implement restorative programs for residents with restorative needs. **MEASURES FOR PREVENTION** *The Unit Supervisors will monitor 3 residents on their hall weekly times four [4], then monthly for compliance of restorative programs being followed. [See Attachment F]* ***QA FOR PREVENTION*** *The Director of Nursing or designee will monitor the results of the "prevention monitoring" for compliance and report monthly to QA meeting.* ***EFFECTIVE DATE*** *The changes are completed and effective by November 28, 2012. Response to letter dated 11/28/2012 addendum F311 All residents receiving restorative programs were reviewed by lead restorative aide. Staff were in-serviced*	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	assisted range of motion exercises with arms and legs, daily for 30 repetitions and ambulation up to 200 feet with contact guard assist to meals daily. A review of therapy screening tool dated 09-28-2012 indicated therapy was not indicated at that time. A care plan titled restorative nursing walk dated 8-1-2012 indicated to cue to complete ADL tasks, use a wheeled walker to walk with staff assist using a gait belt. with no frequency, to walk to meals in dining room, provide rest periods as needed, encourage and praise for completing program. A care plan titled Assisted Range of Motion program dated 8-1-2012 indicated to cue frequently to complete program, try to do 20 repetitions of both upper extremities/lower extremities assisted range Of motion daily, encourage and praise for program participation. An MDS dated 8-2-2012 indicated Resident #89 had participated 2 days in restorative program-and had been discontinued for therapy on 7-31-2012.		*regarding the need to follow restorative plan of care.*	

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	In an observation on 10-25-2012 between 11: 00 AM and 11:45 AM, Resident #89 was not ambulated, was fed in room and placed in bed without ambulation. In an observation on 10-25-2012 between 1:30 P.M. and 2:45 P.M. Resident #89 was not ambulated. In an observation on 10-26-2012 between 8 A.M. and 11:40 A.M., Resident #89 was not ambulated. Resident #89 was served lunch at 11:40 A.M. in his room without being ambulated. In an interview 10-26-2012 at 8:40 A.M., CNA #5 indicated Resident #89 did not go to dining room. CNA #5 further indicated Resident #89 ate in his room and was not being ambulated. In an interview on 10-26-2012 at 10:00 A.M., Restorative Nurse #4 indicated Resident # 89 should have been ambulated to lunch. A current policy dated February 2012 titled Restorative Nursing indicated restorative aides would implement the program. 3.1-38(a)			

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 10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
	3.1-38(a)(2)(A) 3.1-38(a)(2)(B) 3.1-38(a)(2)(C) 3.1-38(a)(2)(D) 3.1-38(a)(2)(E)			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			
	Based on observation, interview and record review the facility failed to ensure 1 of 3 (#41) residents reviewed for ADL care received proper fitting clothing and proper shaving. Finding includes: 1. On 10/24/12 at 1:45 P.M., Resident #41 was noted to be in his room in the wheelchair. The resident's face was noted to be unshaven. The resident's electric shaver was noted to be lying on top of the resident's personal refrigerator in his room. The top to the of the shaver was lying open. The resident indicated he could not put the shaver together and needed help to shave. He did not know why staff had not assisted him to shave. The resident's shirt was also noted to be very tight across the resident's abdomen and his stomach was noted to be exposed between the bottom of the t-shirt and the top of his sweat pants.	F0312	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** Previously purchased shirts will be utilized for Resident # 41. Resident # 41 has a plan in place to address his need for shaving and staff was re-educated to document any refusals. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *Staff were re-educated regarding the importance of shaving residents and the need for proper fitting clothes.* ***MEASURES FOR PREVENTION*** The Unit Supervisors will monitor 3 residents on their hall weekly times four [4], then monthly for compliance for proper fitting clothes and shaving. [See Attachment F] **QA FOR PREVENTION** The Director of Nursing or designee will monitor the results of the "prevention monitoring" for compliance and report monthly to QA. **EFFECTIVE DATE** The changes are completed and effective by November 28, 2012. Response to letter dated 11/28/2012 addendum F312 Staff were in-serviced regarding the need to notify social services for clothing	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	On 10/26/12 at 9:51 A.M., Resident #41 was observed being pushed out of Exercise class. The Resident's face was unshaven and his t-shirt was noted to be too small for him and a little of his belly was exposed. On 10/26/12 at 1:30 P.M., Resident #41 was observed lying in bed asleep. The Resident's face was unshaven, and his electric razor/shaver was still lying on top of his refrigerator with the top open. On 10/29/12 at 8:45 A.M., Resident#41 was noted to be in bed awake, had just finished eating breakfast. His face had been shaved from last week. His razor was noted on his refrigerator but the top had been put together. The Resident said he did shave over the weekend. The last quarterly MDS, completed 10/16/12, indicated the resident required total staff assistance for personal hygiene and extensive assistance for dressing. The current health care plans for Resident #41, current through 01/13, indicated the following: : "Resident requires staff assist to complete his ADL's, is confused at times requiring frequent cues to complete ADL		that do not fit properly. This is communicted via facility concern form.	

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	tasks... Cognitive Loss - ...He requires cues/supervision r/t poor decisions r/t dietary choices and negative behaviors... Psychosocial - ...He needs total care re:ADL's and transfers. (Resident #41's name) continues to need encouragement from SS staff r/t his adjustment issues... ADL's - (Resident #41's name) will complete as much of his own care as he is able with staff assist as needed....monitor for any changes in dressing , bathing and grooming needs and assist as needed and/or encourage him to do as much as he is able..." Review of the behavior tracking for Resident #41 for October 2012 indicated the resident was being tracked for sexually inappropriate behaviors and wetting self. Review of nursing notes from 10/19/12 - 10/29/12, indicated there was no documentation of refusing to allow or do his facial grooming i.e. shaving. Review of social service notes, for October 2012, indicated there was no documentation about any issues with refusing to be shaved, ill fitting clothes, or broken razor.			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	Review of the ADL (Activities of Daily living) record for October 2012, indicated 10/08/12 was the last time resident #41 had been shaved. Interview with the MDS coordinator, RN #20, indicated sometimes the resident refused care, was usually unable to complete his ADL's by himself mostly due to lack of physical endurance due to heart issues. Interview with CNA #6, on 10/29/12 at 11:22 A.M., indicated the resident needed extensive ADL help in the mornings. She indicated the resident needed encouragement and help to shave. She indicated he might be able to shave his chin and a little bit of his face but would need help for most of his face. She also indicated the resident would need encouragement but was usually cooperative. She indicated he would not ask to be shaved but would cooperate with shaving with encouragement and help from staff. 3.1-38(a)			

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 10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review the facility failed to ensure non-pharmacological interventions were attempted before administration of as needed (PRN) psychotropic medications for 3 of 10 residents (#22, 18, 31) reviewed for psychotropic medication use. Findings include:	F0329	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** Psychotropic intervention sheets were implemented in the MAR's for Resident # 18, # 22 and # 31. Staff were re-educated on the need to document non-pharmacological interventions prior to the administration of PRN medications. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *Pharmacological intervention sheets were implemented for all*	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	1. Review of resident #18's clinical record on 10/26/12 at 10:30 A.M. indicated the resident had diagnoses including, but not limited to, insomnia, dementia (Alzheimer's type) and anxiety. Review of the resident's Physician's Orders dated 9/26/12 indicated the resident has an order for Ambien CR 6.25 mg at bedtime PRN insomnia dated 9/7/12. Review of resident #18's MAR indicated use of Ambien 6.25 mg PRN on 9/9/12, 9/10/12; 9/11/12; 9/12/12; 9/13/12. The MAR does not indicate any non-pharmacological interventions attempted before administration of the PRN Ambien for insomnia on those dates. Review of the resident's nurse's notes on 9/9/12, 9/10/12; 9/11/12; 9/12/12; 9/13/12 did not indicate any non-pharmacological interventions attempted before use of Ambien PRN for insomnia on those dates. Review of the resident's health care plans did not indicate specific care plan for the use of Ambien PRN for insomnia. A care plan for mood/behaviors related to a diagnosis of dementia with		*residents receiving PRN psychotropic medications.* ***MEASURES FOR PREVENTION*** During shift change report,licensed staff from both shifts will monitor for complete documentation of non-pharmacological interventions prior to the administration of all PRN psychotropic medications administered during their shift. **QA FOR PREVENTION** The Unit Supervisors will monitor 3 residents on their hall weekly times four [4], then monthly for compliance of non-pharmacological interventions documented on the psychotropic intervention sheets in the MAR's [medication administration record]. The findings will be forwarded to the Director of Nursing and reported findings monthly at QA meeting. [See Attachment F] **EFFECTIVE DATE** The changes are completed and effective by November 28, 2012. Response to letter dated 11/28/2012 addendum F329 Licensed staff were in-serviced regarding the use of non-pharmacological interventions prior to the use of PRN medications.	

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	depression had Ambien added on 9/10/12. The Ambien did not indicate what it's use was for and the care plan did not address insomnia. An interview with the DN on 10/29/12 at 10:45 A.M. indicated the care plan for depression had Ambien added to it on 9/10/12. The DN indicated the care plan does not have interventions or approaches to try before use of the PRN Ambien. Review of the undated facility provided policy titled "Hypnotic Medications" indicated under section I: "Behavior Management plans will be developed for each resident on hypnotic medications." 2. Resident #31's clinical record was reviewed on 10/27/12 at 10:00 A.M.. The record indicated the resident had diagnoses including, but not limited to, anxiety, depression, insomnia and dementia, Alzheimer's type. Review of the physician's orders dated 9/28/12, indicated the resident had an order from 7/21/12 for Lorazepam (a short to medium acting Benzodiazepine)) 0.5 milligrams (mg) twice daily as needed (PRN) for agitation			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	Review of the resident's medication administration record for September and October 2012 indicated the resident received PRN Lorazepam on 9/8/12 at 7:00 A.M. and 10/17/12 at 7:00 P.M.. The MAR did not indicate any interventions attempted before the administration of the PRN Lorazepam on 9/8/12 or 10/17/12. Review of the Mood/Behavior Monitoring Grid for September 2012 did not contain any mood or behavior incidents on 9/8/12. Review of the nurse's note's from 9/8/12 at 7:00 A.M. indicated the resident was "agitated, hollering, yelling at staff. Upset resident won't go to dining room. Given Ativan PRN. No documentation on non-pharmacological interventions were documented before administration of the PRN Ativan on 9/8/12. Review of the Mood/Behavior Monitoring Grid for October 2012 did not contain any mood or behavior incidents on 10/17/12. Review of the nurse's notes for 10/17/12 at 7:00 P.M. indicated resident is crying out, very agitated, crying "I don't know where anyone is"			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	"I want my mom and dad". The nurse's note indicated the resident was medicated with PRN Ativan. The nurse's notes did not indicate any non-pharmacological interventions were attempted before administration of the PRN Ativan. Review of resident #31's health care plan initiated 2/14/11 and reviewed 9/12 indicated Problem/Need: resident has the potential for increased negative behaviors related to diagnosis of dementia and due to his confusion. Resident is being monitored for behaviors of being combative with staff, yelling, attempting to hit others, making verbal threats to staff, having intrusive wandering into other residents' rooms and being threatening towards staff when staff assist to redirect him. Resident has the potential for increased negative moods due to diagnosis of depression. The goal/outcome indicated the resident will accept staff redirection from negative moods and behaviors within 5-10 minutes of observed onset. Interventions included, but were not limited to: encourage participation in activities/events; enjoys talking about wife, children and grandchildren and wife can often assist with redirection over the phone if the resident is			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	upset; use life review therapy as needed to engage including he worked at Harvester, he has been married for over 63 years, he loves to talk about world war 2, he likes country music and he used to like using a metal detector; assess for signs and symptoms of infections. The health care plan did not indicate use of Ativan for agitation. Review of incidents requiring PRN Lorazepam on 9/8/12 and 10/17/12 did not indicate the health care plan was followed for non-pharmacological interventions for agitation or behavioral symptoms. An interview with the director of nursing (DN) at 10:45 on 10/29/12 indicated the resident had a care plan for behaviors in the behavior monitoring book but the care plan was not followed. 3. Resident #22's record was reviewed 10-29-2012 at 9:30 AM. Resident #22's diagnoses included but were not limited to diabetes, confusion, and dementia with depression. A current physician's order summary dated 10-2012 indicated Xanax (an			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	antianxiety medication) was ordered 0.25 milligrams (mg) daily as needed started on 5-26-2012. Physician progress notes dated 9-27-2012 indicated Resident #22 had less delusional symptoms, but to continue medications. There was no mention of anxiety. The Medication Administration Record (MAR) dated October 2012 indicated Xanax 0.25 mg had been given on 10-5-2012. No note indicated non pharmacological interventions had been attempted prior to medicating with Xanax. On 10-8-2012, the MAR indicated Xanax 0.25 mg had been given. No note indicated non -pharmacological interventions had been attempted prior to medicating with Xanax. In an interview on 10-29-2012 at 10:00 AM LPN #5 indicated non-pharmacological interventions were to be noted in the Nurse's notes. LPN #5 further indicated there should always have been a non-pharmacological intervention attempted prior to the administration of an as necessary medication. A review of October Nurse's notes dated 10-5-2012 and 10-8-2012			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	revealed no note of non-pharmacological intervention had been attempted prior to Xanax administration on those days. Review of the undated facility policy titled "Short Acting Benzodiazepine and other Anxiolytic's" indicated "behavioral intervention is a modification of the resident's behavior or environment including staff approaches to care, to the largest degree possible to accommodate the behavioral symptoms." 3.1-48(a)(6)			

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 10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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
F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview the facility failed to ensure staff posting was legible for residents and visitors. Finding includes:	F0356	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** The bottom of the staff posting was moved from a height of 4 feet, 6 and 3/8 inches to a height of approximately2 feet and 10 inches from the floor [just above	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	1. During the initial tour of the facility, conducted on 10/24/12 at 10:30 A.M., the staff posting was noted to be posted outside the Director of Nursing's office on two yellow pieces of paper. The posting was written on the yellow paper in pencil. The graph type form had over 36 lines for staff to write in the names of staff working. The posting was only completed for the shift currently being worked, did not contain the resident census, or the total number of hours worked by each type of employee. The bottom of the posting was hung at approximately 6 foot height from the floor. Interview on 10/29/12 with alert and oriented, wheelchair bound Resident # 42 indicated she could not read the posting forms from her wheelchair. 3.1-13(a)		the chair rail]. The Facility Staff form was revised/updated. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *The Resident Care Coordinator or 200 Hall Nurse will initiate the Staff Posting and update the posting at the beginning of each shift. Staff was re-educated to post the nurse staffing data on a daily basis at the beginning of each shift. [See attachment G]* ***MEASURES FOR PREVENTION*** The Resident Care Coordinator will monitor weekly times 4, then monthly for compliance of staff posting requirements. [See attachment H] **QA FOR PREVENTION** The Director of Nursing or designee will monitor the results of the "prevention monitoring" for compliance and report monthly to QA. **EFFECTIVE DATE** The changes are completed and effective by November28, 2012	

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 10/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE VILLAGE	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(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

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
F0371 SS=F	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 (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation and interview, the facility failed to ensure the ice machine had a proper air gap and was free of debris potentially affecting for 78 of 81 residents who receive liquids orally. Finding includes: During the Environmental Tour, conducted on 10/26/12 from 10:40 - 12:30 P.M., an ice machine was noted in the nourishment pantry. The water condensation pipe, was noted to go underneath the ice machine and through the nourishment pantry wall. The Maintenance staff, Employee #8, indicated the pipe went to a floor drain located in the next room. Observation of the floor drain indicated condensation pipes from both the ice machine and an air conditioner unit were both directed to the same floor drain. The condensation pipers were noted to be touching each other and the air conditioner pipe was resting against	F0371	**CORRECTIVE ACTION FOR AFFECTED RESIDENTS** An ice machine drain check valve was installed to prevent drain back flow and potential contamination. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *See above.* ***MEASURES FOR PREVENTION*** Maintenance staff will monitor and log valve monthly for functionality and cleaning [See Attachment I). **QA FOR PREVENTION** Environmental Services Manager to review maintenance logs monthly for completion and report findings to QA committee monthly. **EFFECTIVE DATE** The changes are completed and effective by November 28, 2012.	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	the rim of the floor drain. A black slimy residue was noted to have accumulated on the end of the ice machine condensation pipe which was in the floor drain. 3.1-21(i)(1)			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
F0465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to provide a homelike environment due to pervasive, and persistent odors., Findings include: On 10/22/12 at 12:00 P.M., the resident room which housed Resident #79 and Resident # 27, was noted to have a very strong urine odor in the room. The odor was pervasive and persistent on the following days and times during the survey: On 10/23/12 at 8:30 A.M. and at 2:00 P.M., Resident #79 and 27's room was again noted to have a strong, ammonia like urine odor. The resident's bathroom, which while attached to the room, had a tiled floor and had the door closed, was not noted to smell as strong as the resident's carpeted room. On 10/23/12 at 8:30 A.M., Resident #79's bed was noted to be unmade and there was a large yellow/brown dried stain on the side of her bedsheet and the cloth incontinence pad.	F0465	**CORRECTIVE ACTION FOR AFFECTED RESIDENT** Resident # 79's room is checked by Environmental Services daily for room odors with additional cleaning as necessary. Nursing will change soiled linen and remove soiled clothes from the room as needed. **IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS** *Environmental and Nursing Staff were re-educated regarding resident room odor elimination including additional cleaning and removal of soiled linen and clothing.* ***MEASURES FOR PREVENTION*** Housekeeping staff will monitor, log and address any resident room odors daily and notify licensed nursing staff for removal of any soiled linen and clothing. [See attachment J] **QA FOR PREVENTION** The Environmental Services Manager and Director of Nursing will review housekeeping logs for completion and will report findings monthly to the QA committee. **EFFECTIVE DATE** The changes are completed and effective by November 28, 2012.	11/28/2012

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	On 10/24/12 at 11:30 A.M. and at 2:30 P.M., Resident room #79 and 27's again was noted to have a strong urine odor. On 10/24/12 at 12:30 P.M., Resident #79's bed was noted to have been sloppily made and when the bedspread was pulled back there was a small yellowish/brown stain noted on the side of the resident's bed linens. On 10/25/12 at 8:30 A.M., Resident #79's bed linens were noted to have yellow brown stains on the side of the bedsheet and the cloth incontinence pad. During the environmental tour of the facility, conducted on 10/26/12 between 10:00 A.M. - 12:30 P.M., resident #79 and 27's was noted to have a strong urine odor. Interview with Food Service Supervisor FSS and Maintenance Supervisor, during the environmental tour indicated Resident #79 had a chair that was possible an issue and would "hide" her wet clothes and/or try to dry out her wet pants by laying them over her chair in her room. Documentation provided by the FSS indicated carpeting in resident #79 and 27's room had been cleaned on			

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 10/29/2012
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814	

(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
	07/28/12, 08/07/12, and on 09/25/12. In addition, on 10/17/12 a chair had been cleaned due to a request from Social Services staff. On 10/26/12, after the Environmental tour of the facility, the carpeting was again being cleaned, Resident #79's chair was being replaced, and more dirty clothes and toilet paper with bowel movement on it was found in the corner behind the resident's chair when it was pulled out. Observation, on 10/29/12 at 10:00 A.M., indicated the urine odor was very strong coming from Room #302 and was noticeable in the hallway outside resident #79 and 27's room, Resident #79 was noted walking down the hallway and did not smell of urine as she ambulated. 3.1-19(f)			