

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 3, 4, 5, 6, 9, 2013.</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Survey team: Tim Long, RN-TC Carole Miller, RN Diane Nilson, RN Rick Blain, RN (9/03, 9/04, 9/05, 9/09)</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census Payor type: Medicare: 5 Medicaid: 69 Other: 8 Total: 82</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 13, 2013 by Randy Fry RN.</p>	F000000		
---------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	--	--

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F000167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure the survey results were readily available for examination for residents and/or visitors.</p> <p>Findings include:</p> <p>During the initial tour of the facility, at 9:55 a.m., on 9/3/13, the survey results were not posted in a readily accessible area and there was no sign to indicate the location of the survey book.</p> <p>The Assistant Director of Nursing Services (ADNS) was interviewed, at 10:00 a.m., on 9/3/13, and indicated the book used to be located on a wall in the main lobby, but it was not there when she looked. She indicated she looked in the Administrator's office, which had been locked, and could not locate the book.</p>	F000167	<p>Enclosed, please find our plan of correction for the deficiencies as identified during our annual survey on September 3, 4, 5, 6, 9, 2013. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction, and that we have consistent quality outcomes. We appreciate your consideration of this request. Upon notification by the survey team, the Survey Binder was placed in the designated lobby area, with outward facing label to ensure easy recognition. No residents or visitors were affected by this practice. Administrator in-serviced office staff on September 26, 2013 on F-167 regulation. Administrator will monitor compliance through normal facility walking rounds. DON or designee will audit placement of the book monthly. The DON will forward the results of the audit to the monthly Quality</p>	10/09/2013
-----------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The Director of Nursing Services (DNS) located the survey book at 10:08 a.m., on 9/3/13, and indicated it was found in the Admission's office.</p> <p>The survey book was noted to be located in a plastic holder mounted on the wall in the front lobby on 9/4 and 9/5/13, at 8:30 a.m., however, the writing on the book indicating it was the survey results, was turned into the wall, so one could not identify this as the survey book, and no signs were posted to identify it was the survey book.</p> <p>The DNS and ADNS were interviewed, at 10:45 a.m., on 9/5/13, and the DNS indicated the book should be turned around so the book could be easily identified.</p> <p>3.1-3(b)(1)</p>		Assurance Meeting for further review and recommendation. The audit will continue monthly for 4 months to ensure continued compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(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			
F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interviews, and record review, the facility failed to ensure a Foley Catheter drainage bag was covered for 1 of 1 residents reviewed for dignity, Resident #147.</p> <p>Findings include:</p> <p>Resident #147 was observed being pushed by a staff member in his wheelchair down the hall to his room, at 11:15 a.m., on 9/3/13. A urinary drainage bag was observed under the wheelchair, uncovered, and yellow urine was observed in the bag.</p> <p>The resident was observed lying in bed, at 12:45 p.m., on 9/4/13, with a Foley Catheter drainage bag hanging on the side of the bed, visible from the door, uncovered, and yellow urine was observed in the bag.</p> <p>The resident was again observed lying in bed, at 2:40 p.m., on 9/4/13, with a visitor present in the room.</p> <p>The Foley Catheter drainage bag was uncovered, and urine could be seen in the drainage bag.</p>	F000241	F 241 The foley catheter bag for resident #147 was covered with a drainage bag cover by the CNA when informed that it had not been covered appropriately. All residents with indwelling catheters could have been affected by this practice. Each resident was observed to ensure that drainage bag covers were in place by the Unit Managers. All nursing staff will be re-educated by the DON/SDC on September 24-26th on the policy and procedure for the application of drainage bag covers and on the dignity policy and procedure. The Unit Manager or designee will complete an audit daily of residents with catheters to ensure that the drainage bag covers are applied per policy. The audits will be forwarded to the DON for review. Further education or disciplinary action will be provided for any noncompliance noted. The DON will forward the results of the audits to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue daily for 30 days, then weekly for 30 days, then monthly thereafter for 4 months to ensure	10/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The resident was observed being pushed by another staff member, in the hallway, at 10:19 a.m., on 9/5/13. The drainage bag was hanging under the wheelchair, but was uncovered.</p> <p>The Director of Nursing Services (DNS )was interviewed at 8:37 a.m., on 9/6/13, regarding the uncovered drainage bag, and indicated the foley catheter drainage bag should be covered.</p> <p>She indicated there was no written policy regarding covering the drainage bag, but indicated the facility did have urinary bag covers to use.</p> <p>3.1-3(t)</p>		continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(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	
F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure call lights were within reach for resident use, for 2 of 35 residents reviewed for call light placement, Residents #50 and #147.</p> <p>Findings include:</p> <p>1. Resident #147 was observed sitting in a wheelchair beside his bed, at 11:30 a.m., on 9/3/13. He indicated he was having pain but could not find his call light. The resident's call light was not visible. LPN #2 was informed the call light could not be found as she was coming into the room with a medication for the resident. After searching for the call light, the nurse indicated it was attached to the upper railing on the bed, but a blanket was covering the call light, so it was not visible. It was out of the resident's reach.</p> <p>Review of the care plan for Resident #147, at 2:00 p.m., on 9/6/13,</p>	F000246	F 246 The call light for resident #147 was placed within reach by the nurse upon notification that it was not visible to the resident. The resident needs were met by the nurse at this time also. The call light for resident #50 was placed within reach by the nurse upon notification that it was not visible to the resident. The resident needs were met by the nurse at this time also. Facility rounds were made by the nursing management to ensure that all residents call lights were within reach. Each resident had the potential to be affected. All staff will be re-educated by the DON/SDC on September 24th -26th, 2013 on the policy and procedure for answering and placement of call lights. The Unit Manager or designee will complete an audit daily to check for appropriate placement of call lights in each room. These audits will be reviewed by the DON. Further education or disciplinary action will be provided for noncompliance noted. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and	10/09/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated the resident was at risk for self-care deficit and required assist to complete activities of daily living (ADL), and was non ambulatory, with approaches including but not limited to:</p> <p>set up supplies and keep in easy reach of the resident prior to each ADL task, and call light to be kept within reach.</p> <p>Another care plan indicated the resident was at risk for falls due to unstable condition and was non-ambulatory, with approaches including but not limited to: place call light within reach and encourage resident to use it.</p> <p>2. Resident # 50 was observed lying in bed, at 2:00 p.m., on 9/3/13. During interview, the resident indicated she was hungry. The call light was not visible, so RN #3 was summoned to the room. After searching, RN#3 indicated the call light was behind the bed and confirmed it was out of the resident's reach. RN#3 indicated the resident was able to use the call light, but didn't normally use the call light, but just waited for staff to come in the room.</p> <p>The resident was observed at 9:14 a.m., on 9/6/13, propelling herself in</p>		<p>recommendation. The audits will continue daily for 30 days, weekly for 30 days, then monthly thereafter for 4 months to ensure continued compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the hallways off the unit where she resided. Her left hand was laying in her lap, but she was using her right hand to pull self along using the handrail.</p> <p>Review of the policy for answering the call light, dated as revised on October 2010, and provided by the DNS at 11:15 a.m., on 9/6/13, indicated the following: "When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. "</p> <p><b>3.1-19(u)(1)</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(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	
F000279 SS=D	<p>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.</p> <p>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.</p> <p>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).</p> <p>Based on observation, interviews, and record review, the facility failed to ensure 2 of 20 residents reviewed for care plans (#17 for dental care and # 4 for an eye infection) had health care plans initiated in a timely manner.</p> <p>Findings include:</p> <p>1. Resident #17, was interviewed at 9:45 a.m., on 9/4/13, and indicated his lower dentures were loose. The resident's lower dentures were noted to be loose and would repeatedly</p>	F000279	F 279 A dental appointment was made for resident # 17 to have her lower dentures adjusted. The care plan was also updated to include the current dental status. The care plan for resident #4 was updated to reflect the current eye infection and isolation. Each residents care plan was reviewed by the nurse management team to ensure that all resident needs and current conditions were addressed in the care plan. Each resident had the potential to be affected. The dental status of each resident was reviewed and any infectious processes. The licensed nursing staff including	10/09/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>come out of his mouth while he was talking.</p> <p>The record for Resident #17 was reviewed at 8:50 a.m., on 9/6/13, and indicated the resident was admitted on 6/12/12.</p> <p>Review of a nursing progress note, dated 3/7/13, indicated the resident was edentulous and had full dentures, and the bottom dentures were loose but the resident denied difficulty chewing.</p> <p>The Annual Minimum Data Set (MDS), dated 5/27/13, provided by the MDS coordinator, at 2:55 p.m., on 9/6/13, indicated under Oral/Dental Status, that the resident had broken or loosely fitting full or partial dentures.</p> <p>The Quarterly Minimum Data Set (MDS), dated 8/20/13, indicated the resident could be understood and had clear comprehension to understand others, and scored 15 on the Brief interview for mental status (BIMs). The MDS further indicated the resident required extensive assistance of one person for dressing, eating, toilet use, and personal hygiene, had no recent weight loss, or swallowing problems, no difficulty with chewing/eating, and</p>		<p>MDS and Unit Managers will be re-educated by the DON/SDC on September 24th-26th, 2013 on the care plan policy and procedure. The Unit Manager or designee will update the care plans and complete an audit daily during the morning clinical meeting based on new orders, change in condition etc. The Unit Manager will forward the results of the audits to the DON. The MDS coordinator or designee will audit all new admission care plans for accurate completion and will audit 5 care plans a week based on MDS schedule to ensure that all needs and areas are addressed. The MDS Coordinator will forward the results to the DON for review. Further re-education or disciplinary action will be given for noncompliance. The DON and Administrator will forward the results of the audits to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue daily for 30 days, weekly for 30 days and then monthly for 4 months to ensure continued compliance. The care plan audits will continue weekly for 30 days and then monthly for 5 months. The quarterly review schedule will then resume if compliance issues have resolved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>no problems with dentures.</p> <p>Resident #17 and a family member were interviewed at 9:25 a.m., on 9/6/13, and indicated he had gotten his current dentures sometime in 2011 and they had fit good. The family member indicated the resident had weighed 230 pounds at that time, but had gotten sick and lost weight so the lower dentures were loose since he had been at this facility. The resident was observed to adjust his lower dentures several times during the interview when he was speaking.</p> <p>CNA #6 was interviewed at 9:55 a.m., on 9/6/13, and indicated the resident wore dentures, was total care and the CNA would place the dentures in the resident's mouth, and took care of them. The CNA indicated the resident's top dentures fit good, but the bottom dentures were loose, and the resident did not like to use the denture grip because it tasted bad.</p> <p>Review of the care plans indicated there was no care plan for dentures or any dental problems.</p> <p>LPN #9 was interviewed, at 10:20 a.m., on 9/6/13, and confirmed there</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was no care plan for dental care.</p> <p>2. The clinical record of Resident #4 was reviewed 9/4/13 at 3:00 P.M. The record indicated Resident #4's diagnoses included, but were not limited to, Methicillian Resistant Staphylococcus Aureus (MRSA).</p> <p>The Resident Progress Notes dated 8/21/13 at 1400 (2:00 p.m.) indicated "...Res (resident) now in contact isolation r/t (related to) information from ophthalmologist that eye culture was + (positive) for MRSA. Res states she has had this before, it is a chronic issue for her."</p> <p>The Physician's Orders dated 8/19/13 indicated bacitracin ophthalmic ointment to both inner lower eyelids at bedtime for 14 days and polytrim 1 drop to each eye 4 times a day for 10 days.</p> <p>There was no Care Plan in regard to the contact isolation for the MRSA in the resident's eyes.</p> <p>Interview with LPN #1 Unit Manager on 9/5/13 at 9:30 a.m. indicated she was unsure if a Care Plan for the contact isolation and MRSA had been done for Resident #4. LPN #1 Unit Manager further indicated when an acute condition was identified the Unit</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Nurse should have initiated a Care Plan for the contact isolation and MRSA.</p> <p>On 9/6/13 at 11:00 a.m. an interview with the Director Nursing Service (DNS) indicated she was unable to find a Care Plan for Resident #4's contact precautions for MRSA in her eyes.</p> <p>The Comprehensive Care Plans Policy, revised on 10/2010, was received from the DNS on 9/9/13 at 10:00 a.m. and indicated: "3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas;...e. Reflect treatment goals...."</p> <p>3.1-35(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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
F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, record review, and interviews, the facility failed to ensure Gastrostomy Tube (GT) medication cups were rinsed to ensure all medication was given for 1 of 1 residents observed for GT medications during a medication pass, Resident #46, and failed to ensure a prn (given as needed) medication was documented as given for 1 of 6 residents observed during medication passes, Resident #147. The facility also failed to ensure a partial medication tablet was destroyed per facility policy, for Resident #24, for 1 of 4 medication carts observed for Medication Storage.</p> <p>Findings include:</p> <p>1. During a medication pass, with LPN #9, at 12:23 p.m., on 9/5/13, the LPN was noted to prepare Gastrostomy tube (GT) medications for Resident #46. The following medications were placed in individual plastic medication cups:</p>	F000281	<p>F 281 Licensed nurse #9 was re-educated on the Medication Administration Enteral Tubes policy and procedure on 9/5/13. Licensed nurse #40 was re-educated on the Medication Administration policy and procedure on 9/4/2013. This education included the documentation and follow up of administering PRN medications. Pharmerica was contacted on 9/09/13 and the medication was redistributed in half tabs as ordered. Each resident with a Gastrostomy tube was reviewed for proper medication administration by the nursing management team. Each resident's MAR was reviewed for proper documentation of PRN medications by the nursing management team. Each resident's MAR was reviewed by the nurse management team for any medications being scored by nurses to ensure proper administration. The licensed nursing staff were re-educated by the pharmacy consultant on Medication Pass Administration policy and procedure on 9/13/2013. The DON/SDC or designee will complete medication pass observations with each nurse by 10/9/13.</p>	10/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Baclofen 20 milligrams 1 tablet per GT (the LPN crushed this medication first)</p> <p>Vitamin D 1000 1 tablet, GT (this was crushed first)</p> <p>Tussin 20 milliliters (400 milligrams) GT</p> <p>Calcium Carbonate suspension 500 milligrams</p> <p>Valproic Acid solution 250/5 milliliters, 3.5 milliliters GT</p> <p>LPN #9 checked the GT for patency and gave water between each of the medications, however, did not rinse the individual medication cups with water after giving each medication to assure all of the medication was administered, except for the very last medication cup which she did pour additional water into, and rinse after giving the medication.</p> <p>Review of the Medication Administration Enteral Tubes Policy, dated 2007, and provided by the Director of Nursing Services (DNS), at 11:15 a.m., on 9/6/13, indicated, Medication administration and flushing of the tube after each individual medication was given was required if there was a known compatibility problem between medications to be mixed together,</p>		<p>Further education or disciplinary action will be provided for noncompliance. The results will be forwarded to the Administrator for review. The Administrator will forward the results of the audits to the monthly Quality Assurance Meeting for further review and recommendations. The medications pass observations will continue until all nurses are compliant. Then will be random weekly audits for 30 days, then random monthly audits on all shifts for 4 months.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and the medication cup was to be rinsed with water to ensure the entire dose of medication had been administered.</p> <p>The Director of Nursing (DNS) was interviewed, at 9:49 a.m., on 9/9/13, and indicated the facility used "Med Pass" company to obtain their policies and procedures for the medication pass.</p> <p>2. During a medication pass, with LPN #40, at 3:39 p.m., on 9/4/13, the LPN was observed to give Resident #147 Flexeril 10 milligrams, by mouth. The resident record and Medication Administration Record (MAR) was reviewed at 1:45 p.m., on 9/9/13, and indicated a physician's order for Flexeril 10 milligrams, 1 by mouth, as needed for muscle spasms, but there was no documentation this medication had been given , at 3:39 p.m., on 9/4/13.</p> <p>The Unit Manager, LPN # 5 was interviewed at 1:45 p.m., on 9/9/13, and confirmed the Flexeril had not been documented as given.</p> <p>Review of the policy "Medication Administration", dated 2007, and provided by LPN #5, at 1:40 p.m., on 9/6/13, and reviewed at 1:50 p.m., on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>9/9/13, indicated, "Chart medication administration on Medication Administration Record immediately following each resident's medication administration. "</p> <p>3. The medication cart for 200 hall was checked for medication storage, with LPN #4 at 10:28 a.m., on 9/9/13. There was a bubble pack of Fazaclo (Clozapine)( an antipsychotic medication) 25 milligram tablets in the locked narcotic drawer for Resident # 24.</p> <p>The instructions on the bubble pack indicated to give the clozapine, 1/2 tablet by mouth every evening and 1 and 1/2 tabs (37.5 milligrams) every evening at bedtime. The tablets were whole and were not scored on the side of the tablet which could be seen. Instructions on the packet also indicated the facility was to split the tablets.</p> <p>Lpn #4 was interviewed at 10:30 a.m., on 9/9/13, and indicated this medication was given on the evening shift, so she didn't know how staff on the evening shift broke the tablets or stored the half tablet that was not given at suppertime. LPN #4 indicated she could not tell if the tablets were scored because she could not see the back of the pill.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The resident record for Resident #24 was reviewed at 10:45 a.m., on 9/9/13, and physician orders indicated the following: Fazaclo 12.5 milligrams tablet, by mouth daily at supper time (dated 5/18/12), and Fazaclo 37.5 milligrams, by mouth at bedtime. ( dated 11/29/12).</p> <p>LPN #1, a Unit Manager, was interviewed at 10:48 a.m., on 9/9/13, and indicated she was not sure how the evening shift nurses split the tablets, but indicated they probably broke the tablet in half, and gave 1/2 the tablet at supper and then saved the other 1/2 tablet in the narcotic drawer for the bedtime medication pass, and gave it with another whole pill at bedtime to equal 1 and 1/2 tablets. She indicated she couldn't tell if the tablets were scored, but she would call the pharmacy and the evening shift nurse to ask them.</p> <p>LPN #1 was interviewed at 10:56 a.m., on 9/9/13, and indicated she had called the pharmacist and the pharmacist indicated he had "googled it" and the tablets were not scored. She indicated the pharmacist also recommended to change the order to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>25 milligrams (mg) instead of 12.5 mg.</p> <p>LPN #1 was interviewed at 11:40a.m. on 9/9/13 and indicated she had called the evening shift nurse who had been working on that unit and the evening shift nurse had told her the tablets were not scored and he had been breaking them in half and giving one at dinnertime, and saving the other half in a medication cup in the narcotic drawer for the bedtime dosage. LPN #1 also indicated the facility policy said the tablets could not be saved for later, but had to be destroyed if not used.</p> <p>The policy for "Crushing Medications", dated as revised on December 2011, and provided by LPN #1, at 11:40 a.m., on 9/9/13, was reviewed at 12:17 p.m., on 9/9/13 and indicated, "If a partial tablet is ordered, the nurse should break the tablet on the scored line. Hands must be cleaned before breaking the tablet. The other half tablet is to be discarded. (Note: The Vendor Pharmacist may be contacted to provide the half-tablet doses, thus eliminating the need for the nurse to split the tablets in half.)"</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(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	
	3.1-35(g)(1)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review, and interview, the facility failed to ensure physician orders were followed for 1 resident in a sample of 5 residents reviewed for unnecessary medication use, Resident #147. In addition, the facility failed to follow the nursing care plan for dental services for 1 of 20 residents reviewed for care plans (Resident #119).</p> <p>Findings include:</p> <p>1. The record for Resident #147 was reviewed at 10:30 a.m., on 9/5/13, and indicated the resident was admitted on 8/23/13. A physician's order, dated 8/23/13, indicated Cephalexin (an antibiotic) 250 milligrams, 2 (500 milligrams) by mouth three times a day times 10 days.</p> <p>Review of the Medication Administration Record (MAR) for August, 2013, indicated the resident had received the Cephalexin three times a day as ordered between 8/24 and 8/31/13 (48 capsules).</p> <p>Review of the MAR for September,</p>	F000282	F 282 The physician was notified on 9/5/13 of the medication discrepancy for resident #147 and an order for a U/A was obtained for follow up. An I&O sheet was initiated for resident #45 on 9/5/2013 in order to monitor intake and output related to the order for the fluid restriction. Resident #119 was seen by the dentist on 9/19/2013 for evaluation of the loose fitting dentures. Each residents MAR was reviewed by the nursing management team for any further medication discrepancies. Each resident with an order for fluid restriction was reviewed by the nursing management team for proper documentation of intake and output. Each resident will have a dental assessment completed by the nursing management team to ensure that all dental needs are being met. The care plans will be updated at the time of assessment. All residents had the potential to be affected by this practice. The licensed nursing staff will be re-educated on the intake and output policy and procedure related to fluid restriction, the dental assessment policy and procedure and the medication	10/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2013, indicated the resident received Cephalexin 250 milligrams by mouth three times a day.</p> <p>The cephalexin 250 milligrams was documented on the September MAR as being given on 9/1 and 9/2/13, three times on each day (6 capsules), then discontinued.</p> <p>The Unit Manager, LPN #5, was interviewed, at 1:25 p.m., on 9/6/13, and indicated when the medical records person re-wrote the MARs for September, 2013, she wrote the order incorrectly and it should have read Cephalexin, 250 milligrams, 2 capsules, three times a day.</p> <p>The medication bubble packs were pulled from the medication cart, by LPN #5, at 1:25 p.m., on 9/6/13. There were 2 bubble packs in the medication cart, both dated 8/23/13, (date pharmacy sent). LPN #5 indicated there were 30 capsules sent in each pack, a total of 60 capsules being sent. There were capsules observed remaining in the bubble packs, the one bubble pack contained 3 capsules, and the second bubble pack contained 14 capsules, a total of 17 capsules.</p> <p>LPN #5 indicated some of the capsules were probably pulled from</p>		<p>administration policy and procedure by the DON/SDC on Sept 24-26th, 2013. The Social Service Director will be re-educated by the DON/SDC on the dental follow up policy and procedure on September 24, 2013. The Unit Manager or designee will complete an audit monitoring each resident with a fluid restriction daily. The Unit Manager or designee will audit the MAR for accurate physician orders daily. All nurses will receive a medication administration observation by the SDC to ensure compliance. The MDS Coordinator or designee will audit each new admission for dental issues and notify SSD of any issues needing follow up. Dental issues will also be reviewed quarterly by the MDS Coordinator for in house residents to ensure dental assistance is provided as needed. The results of the audits will be forwarded to the DON for review. Further education or disciplinary will be provided for any noncompliance noted. The DON will forward the results of the audits to the monthly QA meeting for further review and recommendation. The audits will continue daily for 30 days, weekly for 30 days, then monthly for 4 months to ensure continued compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the Emergency Drug Kit (EDK) before the medication arrived from the pharmacy. When the EDK was checked by the Unit Manager at 1:30 p.m., on 9/6/13, she indicated only 4 capsules had been taken from the EDK for this resident. Thus the resident should have received 60 capsules, but only received 47 of the capsules.</p> <p>Review of the care plan, dated 8/23/13, indicated a potential for dehydration related to Urinary Tract Infection, with a goal the resident's foley catheter would be kept patent and resident would be free of signs and symptoms of infection. The approaches included, but not limited to: Medications to be given as ordered by the physician, and antibiotic as ordered.</p> <p>Review of the policy for Medication Administration, dated 2007, and provided LPN #5, at 1:40 p.m., on 9/6/13, indicated the following: "Review and confirm medication orders for each individual resident on the Medication Record prior to administering medication", and "Pour the correct number of tablets or capsules into the medication cup, taking care to avoid touching any of the medication unless wearing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>gloves."</p> <p>2. Resident #45's clinical record was reviewed on 9/5/13 at 9:00 A.M. The record indicated the resident has a physician's order for a fluid restriction of 1500 milliliters (ml) daily. The physician's order divided the fluids to be administered to the resident as: 8:00 A.M. medication pass = 150 ml; 12:00 meal = 120 ml; 6:00 P.M. medication pass = 150 ml; 8:00 medication pass = 150 ml; NEPHRO x 2 cans = 480 ml; dietary + 480 ml.</p> <p>Review of the medication administration record (MAR) for August 2013, indicated a notation for fluid restriction 1500 ml daily: 1020 ml = nursing; 480 ml = dietary. The notation is signed each shift by a nursing staff. No recording of actual fluid intake is documented on the MAR.</p> <p>Review of a health care plan initiated on 3/19/13 and revised on 3/20/13 indicated the focus as: Resident has hemodialysis Monday, Wednesday and Friday and is non-compliant with fluid restriction orders. The interventions include: Monitor and evaluate food/beverage intake via meal intake records and observation; Restrict fluids as ordered by the physician.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

	<p>An interview with the assistant director of nursing (ADN) on 9/5/13 at 8:39 A.M. indicated resident #45 had a physician's order for fluid restriction of 1500 ml daily and it was to be recorded on the MAR. The ADN indicated there was to be a intake and output ( I&amp;O ) sheet on the MAR but resident #45 did not have one on the MAR. The ADN also indicated resident #45 was non-compliant with fluid restriction.</p> <p>Review of the facility policy provided by the ADN on 9/6/13 at 10:00 A.M. titled Fluid Restriction, effective 12-2010, under the procedure section, #4, indicated, "Document strict I &amp; O each shift".</p> <p>Resident #119 was interviewed on 9/4/13 at 9:03 a.m. in regard to dental problems and the resident indicated she needed denture work but could not afford the work to her dentures.</p> <p>The clinical record of Resident #119 was reviewed on 9/5/13 at 2:00 p.m. The record indicated Resident #119's diagnoses included, but were not limited to, diabetes and asthma.</p> <p>Resident #119 Care Plan initiated on 4/4/13 indicated the resident had not</p>			
--	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>worn her upper dentures because the upper denture was "...ill fitting' in her mouth. The Care Plan further indicated to refer the resident to the dentist as needed.</p> <p>There was no documentation to indicate the resident had seen a Dentist.</p> <p>On 9/5/13 at 2:00 p.m. the Social Service Director (SSD) was interviewed and indicated the resident had never told the SSD about wanting dentures.</p> <p>On 9/5/13 at 3:00 p.m., the SSD was interviewed with LPN #1 Unit Manager present in regard to Resident #119's dentures. The SSD indicated the former SSD for the B wing left, and she thought the former SSD initiated the Care Plan on 4/4/13 in regard to Resident #119's dentures.</p> <p>On 9/6/13 at 11:00 a.m. the Assistant Director of Nursing Service was interviewed and indicated she had reviewed Resident #119's Nurses Notes and SSD notes for April 2013 and there was no documentation to indicate the resident needed to see the Dentist in regard to her loose dentures.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 9/6/13 at 11:00 a.m. the Director Nursing Service (DNS) indicated Resident #119 had not voiced any concerns to the DNS in regard to the resident's dentures not fitting correctly.</p> <p>The Dental Services policy received from the DNS on 9/9/13 at 10:00 a.m. revised April 2010 indicated "Routine... dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.</p> <p>12. The Director of Nursing Services, or his/her designee, is responsible for notifying Social Services of a resident's needs for dental services.</p> <p>13. Social Service personnel will be responsible for assisting the resident/family in making dental appointments...."</p> <p>3.1-35(g)(2)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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
F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure it was free of medication errors in that there were 2 medication errors in an opportunity for 29, (Residents # 113 and #148), a 6.8% error rate.</p> <p>Findings include:</p> <p>1. During a medication pass, with LPN #10, at 4:00 p.m., on 9/4/13, the LPN drew up 10 units of Novolog insulin into a syringe and administered the medication subcutaneously (SQ) to Resident #113.</p> <p>The LPN indicated she had taken the resident's blood sugar reading earlier and it was 301. She indicated 5 units of the insulin was given for the high blood sugar reading, and 5 units was given as a routine dose. She indicated the resident did not eat dinner until 5:45 p.m. to 6:00 p.m., but the insulin was ordered to give earlier.</p> <p>The resident record was reviewed at 8:30 a.m., on 9/6/13.</p>	F000332	<p>F 332 LPN #10 was re-educated on the insulin administration policy and procedure on 9/4/13. LPN #2 was re-educated on the insulin administration policy and procedure on 9/5/2013. Each resident's MAR was reviewed for appropriate insulin administration times by the nursing management team. All orders were clarified by the physician so that the insulin is being administered according to facility policy and procedure associated with meal times. All insulin dependent diabetics had the potential to be affected. The licensed nursing staff were re-educated by the pharmacy consultant on Medication Pass Administration policy and procedure on 9/13/2013. The DON/SDC or designee will complete medication pass observations with each nurse by 10/9/13. Further education or disciplinary action will be provided for noncompliance. The results will be forwarded to the Administrator for review. The Administrator will forward the results of the audits to the monthly Quality Assurance Meeting for further review and recommendations. The medications pass observations</p>	10/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Physician orders for September 2013, indicated an order for Novolog 5 units SQ with meals, with an order date of 7/25/13. Also, an order for Novolog(Insulin Aspart) SQ prior to meals no coverage at bedtime as follows: 150-200 2 units, 201-250 3 units, 251-300 4 units, 301-350 5 units, and to contact the physician of blood sugar reading was greater than 350 or less than 60.</p> <p>Review of the Medication Administration Record (MAR) for August and September, 2013, indicated Novolog 5 units SQ with meals , with times scheduled 0800, 12 noon, and 1600 (4:00 p.m.)</p> <p>Review of the Diabetic Monitoring flowsheets for August and September 2013, indicated the evening insulin coverage for elevated blood sugars prior to the evening meals was being given at 1600 (4:00 p.m.) .</p> <p>The DNS was interviewed at 8:30 a.m., on 9/6/13 and indicated there was no written policy on insulin regarding time frames prior to meals, but agreed giving the insulin 2 hours prior to a meal was too early. (According to the 2010 Nursing Spectrum Handguide for Drugs, Novolog Insulin was to be given 5-10 minutes before meals.)</p>		will continue until all nurses are compliant. Then will be random weekly audits for 30 days, then random monthly audits on all shifts for 4 months.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The Dietician was interviewed at 8:42 a.m., on 9/6/13, and indicated the food trays were set up for the Reflection Unit where Resident #113 resided starting at 7:50 a.m, 11:50 a.m., and 5:50 p.m., and would arrive on the reflection unit approximately 10 minutes later. She indicated the dinner tray would arrive at approximately 6:00 p.m.</p> <p>2. On 9/5/13 at 11:08 A.M. an observation was made of resident #148 being administered Humalog (a rapid acting insulin) 9 units subcutaneously by LPN #2. At 12:24 P.M. resident #148 was observed being served his lunch in the main dining room.</p> <p>An interview with LPN #2 at 11:10 A.M. indicated she usually gives resident #148 his insulin at this time daily. LPN #2 stated the resident eats at 12:00 P.M. and the medication administration record indicated to give his Humalog at 11:30 A.M. before lunch. LPN #2 indicated the resident received Humalog 5 units routine and another 4 units for coverage for a blood sugar reading of 164.</p> <p>Review of resident #148's clinical record indicated on 8/29/13 physician's order's were received for Humalog 5 units before lunch and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Humalog sliding scale coverage, which indicated for a blood sugar reading between 151-200 the resident was to receive 4 units of Humalog.</p> <p>An interview with the assistant director of nursing (ADN) on 9/5/13 at 2:45 P.M. indicated she thought Humalog should be given 10-15 minutes before a meal.</p> <p>Review of the policy provide by the ADN on 9/5/13 at 2:45 P.M., titled Insulin Administration, from the "Nursing Services Policy and Procedure Manual, 2001 MED PASS, Inc (Revised October 2010)" indicated for a rapid acting insulin the onset of action as 10-15 minutes.</p> <p>Review of the drug handbook provided by the ADN (Davis's Drug Guide for Nurses, eleveth edition) on 9/5/13 at 2:30 P.M. indicated for Humalog insulin to administer "within 15 minutes before or immediately after a meal".</p> <p>3.1-48(c)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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
F000411 SS=D	<p><b>483.55(a)</b> <b>ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</b> The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on record review and interviews, the facility failed to ensure 1 of 3 residents reviewed for dental status, Resident #119, was referred for dental care.</p> <p>Findings include:</p> <p>Resident #119 was interviewed on 9/4/13 at 9:03 a.m. in regard to dental problems and the resident indicated she needed denture work but could not afford the work to her dentures.</p> <p>The clinical record of Resident #119 was reviewed on 9/5/13 at 2:00 p.m. The record indicated Resident #119's diagnoses included, but were not</p>	F000411	F 411 Resident #119 was evaluated by the dentist on 9/19/2013. The resident has declined to have a new partial made at this time. Each resident had a dental assessment completed by the nursing management team to ensure there were no outstanding dental problems. The care plans were updated as the assessment was completed. Residents who were in need of dental services were referred to the Social Service Director for follow up. Each resident has the potential to be affected by this practice. The licensed nursing staff will be re-educated by the DON/SDC on Sept 24-26th, 2013 on the dental assessment policy and procedure to include referring issues noted to the Social Service Director. The Social Service Director will	10/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>limited to, diabetes and asthma.</p> <p>Resident #119 Care Plan initiated on 4/4/13 indicated the resident had not worn her upper dentures because the upper denture was "...ill fitting' in her mouth. The Care Plan further indicated to refer the resident to the dentist as needed.</p> <p>There was no documentation to indicate the resident had seen a Dentist.</p> <p>On 9/5/13 at 2:00 p.m. the Social Service Director (SSD) was interviewed and indicated the resident had never told the SSD about wanting dentures.</p> <p>On 9/5/13 at 3:00 p.m. the SSD was interviewed, with LPN #1 Unit Manager present, in regard to Resident #119's dentures. The SSD indicated the former SSD for the B wing left, and she thought the former SSD initiated the Care Plan on 4/4/13 in regard to Resident #119's dentures.</p> <p>On 9/6/13 at 11:00 a.m. the Assistant Director of Nursing Service was interviewed and indicated she had reviewed Resident #119's Nurses Notes and SSD notes for April 2013</p>		<p>be re-educated by the DON/SDC on Sept 24, 2013 on the dental referral policy and procedure. The Unit Manager or designee will audit all new admissions for appropriate dental assessment and follow up. The MDS Coordinator or designee will audit each resident quarterly for appropriate dental assessment and follow up with Social Service Director as needed. The audits will be forwarded to the DON for review. Further education and disciplinary action will be provided as needed for noncompliance noted. The DON will forward the results of the audits to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue with each new admission for 90 days, then quarterly on each resident indefinitely to ensure continued compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and there was no documentation to indicate the resident needed to see the Dentist in regard to her loose dentures.</p> <p>On 9/6/13 at 11:00 a.m. the Director Nursing Service (DNS) indicated Resident #119 had not voiced any concerns to the DNS in regard to the resident's dentures not fitting correctly.</p> <p>The Dental Services policy received from the DNS on 9/9/13 at 10:00 a.m. revised April 2010 indicated "Routine... dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.</p> <p>12. The Director of Nursing Services, or his/her designee, is responsible for notifying Social Services of a resident's needs for dental services.</p> <p>13. Social Service personnel will be responsible for assisting the resident/family in making dental appointments...."</p> <p>3.1-24(a)(1) 3.1-24(a)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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
F000412 SS=D	<p><b>483.55(b)</b> ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interviews, and record review, the facility failed to ensure 1 of 3 residents reviewed for dental status, Resident #17 was referred for dental care.</p> <p>Findings include:</p> <p>Resident #17, was interviewed at 9:45 a.m., on 9/4/13, and indicated his lower dentures were loose. The resident's lower dentures were noted to be loose and would repeatedly come out of his mouth while he was talking.</p> <p>The record for Resident #17 was reviewed at 8:50 a.m., on 9/6/13, and indicated the resident was admitted on 6/12/12.</p> <p>Review of a nursing progress note, dated 3/7/13, indicated the resident was edentulous, had full dentures,</p>	F000412	F 412 Resident #17 had a dental consent signed on 9/6/13. Resident #17 was evaluated by the dentist on 9/19/2013. Each resident had a dental assessment completed by the nursing management team to ensure there were no outstanding dental problems. The care plans were updated as the assessment was completed. Residents who were in need of dental services were referred to the Social Service Director for follow up. The documentation was reviewed on each chart for dietary, nursing, and the MDS to ensure all were correct. Each resident has the potential to be affected by this practice. The licensed nursing staff will be re-educated by the DON/SDC on Sept 24-26th, 2013 on the dental assessment policy and procedure to include referring issues noted to the Social Service Director. The Social Service Director will be re-educated by the DON/SDC on Sept 24, 2013	10/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and the bottom dentures were loose but the resident denied difficulty chewing.</p> <p>Review of the most recent nutrition therapy assessment, dated 6/4/13, and provided by the Dietician (RD) at 10:35 a.m., on 9/6/13, indicated no swallowing problems. Under the section for dentures and loose/ill fitting dentures, nothing was marked. The RD was interviewed, at 10:35 a.m., on 9/6/13, and indicated she did not actually observe his dentures on this assessment, but had gotten information from the nursing notes regarding dentures, and there was nothing documented in nursing notes regarding the dentures so she didn't mark any concerns.</p> <p>The Annual Minimum Data Set (MDS), dated 5/27/13, provided by the MDS coordinator, at 2:55 p.m., on 9/6/13, indicated under Oral/Dental Status, that the resident had broken or loosely fitting full or partial dentures.</p> <p>The Quarterly Minimum Data Set (MDS), dated 8/20/13, indicated the resident could be understood and had clear comprehension to understand others, and scored 15 on the Brief interview for mental status (BIMs).</p>		<p>on the dental referral policy and procedure. The Dietician will be re-educated by the DON/SDC on Sept 24, 2013 on the documentation of dental status policy and procedure. The Unit Manager or designee will audit all new admissions for appropriate dental assessment, correct dietary documentation and follow up. The MDS Coordinator or designee will audit each resident quarterly for appropriate dental assessment and follow up with Social Service Director as needed. The audits will be forwarded to the DON for review. Further education and disciplinary action will be provided as needed for noncompliance noted. The DON will forward the results of the audits to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue with each new admission for 90 days, then quarterly on each resident indefinitely to ensure continued compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The MDS further indicated the resident required extensive assistance of one person for dressing, eating, toilet use, and personal hygiene, had no recent weight loss, or swallowing problems, no difficulty with chewing/eating, and no problems with dentures.</p> <p>A "Medical Nutrition Therapy Review" , dated 8/20/13, indicated the resident had had a decrease in self feeding related to progression of dementia as evidenced by varied meal intakes and requesting to be fed at meals, but reported good appetite and requiring less feeding at meals. . Also there were no oral, dental, or swallow problems.</p> <p>Resident #17 and a family member were interviewed at 9:25 a.m., on 9/6/13, and indicated he had gotten his current dentures sometime in 2011 and they had fit good. The family member indicated the resident had weighed 230 pounds at that time, but had gotten sick and lost weight so the lower dentures were loose since he had been at this facility. The resident was observed to adjust his lower dentures several times during the interview when he was speaking.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>CNA #6 was interviewed at 9:55 a.m., on 9/6/13, and indicated the resident wore dentures, was total care and the CNA would place the dentures in the resident's mouth, and took care of them. The CNA indicated the resident's top dentures fit good, but the bottom dentures were loose, and the resident did not like to use the denture grip because it tasted bad.</p> <p>The Social Service Director was interviewed at 10:10 a.m., on 9/6/13 and indicated she was in charge of getting the consents signed for dental care, but she could not find a signed consent for this resident, from the company who handled the facility dental issues. She indicated the resident must have had a consent form signed at some point, because the resident had been seen for eye care, and the consent included eye care as well as dentistry care. She indicated she would get a consent form signed and get the resident on the list today to see the dentist.</p> <p>The Social Service Director was interviewed, at 2:55 p.m., on 9/6/13, and indicated the resident had been on Medicaid since April 2013.</p> <p>The Dental Services policy received from the DNS on 9/9/13 at 10:00 a.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>revised April 2010 indicated "Routine... dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. 12. The Director of Nursing Services, or his/her designee, is responsible for notifying Social Services of a resident's needs for dental services. 13. Social Service personnel will be responsible for assisting the resident/family in making dental appointments...."</p> <p>3.1-24(a)(1) 3.1-24(a)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(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			
F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure partial medication doses not given were destroyed for Resident</p>	F000431	F 431 The pharmacy was contacted on 9/9/2013 and the medication was sent from the pharmacy in 1/2 tablets. Each resident's MAR and medication	10/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p><b>#24, as per facility policy, for 1 of 4 medication carts checked for medication storage.</b></p> <p>Findings include:</p> <p>The medication cart for 200 hall was checked for medication storage, with LPN #4 at 10:28 a.m., on 9/9/13. There was a bubble pack of Fazaclo (Clozapine)( an antipsychotic medication) 25 milligram tablets in the locked narcotic drawer for Resident # 24.</p> <p>The instructions on the bubble pack indicated to give the clozapine, 1/2 tablet by mouth every evening and 1 and 1/2 tabs (37.5 milligrams) every evening at bedtime. The tablets were whole and were not scored on the side of the tablet which could be seen. Instructions on the packet also indicated the facility was to split the tablets.</p> <p>Lpn #4 was interviewed at 10:30 a.m., on 9/9/13, and indicated this medication was given on the evening shift, so she didn't know how staff on the evening shift broke the tablets or stored the half tablet that was not given at suppertime. LPN #4 indicated she could not tell if the tablets were scored because she could not see the back of the pill.</p>		<p>cart was reviewed by the nursing management team to ensure that there were no other medications being administered/stored following this procedure. There were no other residents found to be affected. The licensed nursing staff will be re-educated by the DON/SDC on the policy and procedure for storing and disposal of medications on Sept 24-26th, 2013. The SDC or designee will audit the medication carts weekly for proper storage of and destruction of medications. The audits will be given to the DON for review. Further education of disciplinary action will be completed for noncompliance noted. The DON will forward the results of the audits to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue weekly for 30 days, then every other week for 30 days, and then monthly for 4 months to ensure continued compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The record for Resident #24 was reviewed at 10:45 a.m., on 9/9/13, and physician orders indicated the following: Fazaclo 12.5 milligrams tablet, by mouth daily at supper time (dated 5/18/12), and Fazaclo 37.5 milligrams, by mouth at bedtime. ( dated 11/29/12).</p> <p>LPN #1, a Unit Manager, was interviewed at 10:48 a.m., on 9/9/13, and indicated she was not sure how the evening shift nurses split the tablets, but indicated they probably broke the tablet in half, and gave 1/2 the tablet at supper and then saved the other 1/2 tablet in the narcotic drawer for the bedtime medication pass, and gave it with another whole pill at bedtime to equal 1 and 1/2 tablets. She indicated she couldn't tell if the tablets were scored, but she would call the pharmacy and the evening shift nurse to ask them.</p> <p>LPN #1 was interviewed at 10:56 a.m., on 9/9/13, and indicated she had called the pharmacist and the pharmacist indicated he had "googled it" and the tablets were not scored. She indicated the pharmacist also recommended to change the order to 25 milligrams (mg) instead of 12.5</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>mg.</p> <p>LPN #1 was interviewed at 11:40a.m. on 9/9/13 and indicated she had called the evening shift nurse who had been working on that unit and the evening shift nurse had told her the tablets were not scored and he had been breaking them in half and giving one at dinnertime, and saving the other half in a medication cup in the narcotic drawer for the bedtime dosage. LPN #1 also indicated the facility policy said the tablets could not be saved for later, but had to be destroyed if not used.</p> <p>The policy for "Crushing Medications", dated as revised on December 2011, and provided by LPN #1, at 11:40 a.m., on 9/9/13, was reviewed at 12:17 p.m., on 9/9/13 and indicated, "If a partial tablet is ordered, the nurse should break the tablet on the scored line. Hands must be cleaned before breaking the tablet. The other half tablet is to be discarded. (Note: The Vendor Pharmacist may be contacted to provide the half-tablet doses, thus eliminating the need for the nurse to split the tablets in half.)"</p> <p>3.1-25(j)(k)(l)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2013
-----------------------------------------------------	--------------------------------------------------------------------	--------------------------------------------------------------	--------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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:  155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(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			
F000463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure a bedside call light was functioning for 1 of 35 residents reviewed for call light function, Resident #128.</p> <p>Findings include:</p> <p>During an interview with a family member of Resident #128, at 2:53 p.m., on 9/3/13, the call light near the resident's bedside did not function when checked, and the light outside the resident's room did not go on when checked . LPN #1, the Unit Manager, was summoned to the room, and tried to turn on the call light and indicated it did not work and she would have to call Maintenance. The Maintenance man was observed checking the call light in the resident's room at 2:56 p.m., on 9/3/13, and at 3:00 p.m., the Maintenance man was observed taking a new call light into the resident's room, and the call light outside the resident's room was noted to light up when checked by the</p>	F000463	F 463 The call light system for resident #128 was replaced and checked by facility maintenance. Facility rounds were made by maintenance staff to ensure that all residents call lights were functioning properly. Each resident had the potential to be affected. All staff will be re-educated by the DON/SDC on September 24th -26th, 2013 on the policy and procedure for submitting work orders and reporting of non-functioning call lights. The Plant Operations Manager or designee will complete an audit monthly to check for appropriate function of call lights in each room. The results of the audits will be forwarded to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue monthly on-going to ensure continued compliance.	10/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Maintenance man.</p> <p>Review of the policy "Call Systems" dated January 2005, and provided by the Director of Nursing Services (DNS), at 11:15 a.m., on 9/6/13, indicated, "We will maintain a functioning call system in all portions of the building that residents use. This system shall be checked monthly by the maintenance department."</p> <p><b>3.1-19(u)(1)</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(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	
F000520 SS=C	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review the facility failed to ensure the medical director attend the quality assessment and assurance committee meetings quarterly.</p> <p>Findings include:</p> <p>An interview with the facility administrator on 9/9/13 at 1:00 P.M. indicated the medical director participates in the quality assessment</p>	F000520	F 520 The QA Committee, including Medical Director met on September 18, 2013. QA Committee meeting schedule was reviewed to ensure compliance. All residents could have been affected by this practice. QA Committee will be re-educated on September 27th on the policy and procedure for F-520. The DON or designee will complete a monthly audit of the QA Committee attendance to ensure Medical Director is present per regulation. The DON will forward	10/09/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/09/2013
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and assurance committee meetings by reviewing a report sent to him after the meeting.</p> <p>An interview with the Director of Nursing on 9/9/13 at 1:15 P.M. indicated the medical director attends the quality assessment and assurance committee meetings quarterly. The Director of Nursing provided copies of the attendance sheets for the quality assessment and assurance committee meetings from the past year which indicated the medical director attended the August 2013 and the September 2012 meetings only in the past year.</p> <p>3.1-52(a)(2)</p>		<p>the results of the audits to the monthly Quality Assurance Meeting for further review and recommendation. The audits will continue monthly for 6 months to ensure continued compliance.</p>		