

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2016
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200074.</p> <p>Complaint IN00200074 - Substantiated, deficiencies cited at F-282 and F-309.</p> <p>Survey Dates: May 16, 17 & 18, 2016</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 2 Medicaid: 63 Other: 13 Total: 78</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16-2 3.1</p> <p>QR completed on May 19, 2016 by 17934.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0282 SS=D Bldg. 00	<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 follow a physicians order for 1 resident (B) in a sample of 3 resident records reviewed.</p> <p>Findings include:</p> <p>On 5/17/16 at 9:00 a.m. review of the clinical record for resident (B) indicated he was admitted to the facility on 4/4/16 with Diagnoses including but not limited to Metastatic Melanoma, Diabetes, Neuropathy, Obesity, Depression, Clostridium Difficile, and Surgical Ulcer of the Left Great Toe.</p> <p>Further review of the clinical record for resident (B) on 5/17/16 at 1:15 p.m. indicated a "Clinical Visit Summary" from the orthopedic surgeon dated 4/18/16. Review of the summary indicated "Sutures were removed today on the toe. He should continue to dress the wound with a very thin layer of antibiotic ointment and then a dry</p>	F 0282	<p>Services by qualified person/care plan</p> <p>F 282 Failure to follow Physician's order</p> <ol style="list-style-type: none"> 1. Unit Manager was put into place on 5/16/16 to oversee the unit. 2. Unit Manager was trained on 5/13/16 to oversee the unit. 3. Re-education is scheduled for 100% of Nurses regarding review of all documentations, writing orders from outpatient visits in a timely fashion on 6/10/16 4. UM or designee to review all documentation from outpatient visits daily and audit follow through process. 5. DON to conduct morning clinical meeting daily and review with IDT members findings from outpatient visits. DON will pull and review omission report daily. 6. DON or designee to spot check outpatient documentation for accuracy of follow through bi-weekly x4, weekly x4, bi-monthly x8 then monthly. 	06/10/2016

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F 0309 SS=D Bldg. 00	<p>nonstick dressing. He should be elevating the legs when in bed, above heart level, on 2-3 pillows to help with swelling."</p> <p>Review of the "April and May 2016 Medication/Treatment Records" on 5/17/16 at 1:30 p.m. did not indicate this order was entered into the computerized treatment records for resident (B) and there was no documentation of the order being followed.</p> <p>Interview with the Corporate Nurse Consultant on 5/18/16 at 9:00 a.m. indicated nursing staff did not implement the orthopedic physicians order for resident (B). She indicated an order had been received by the nurse practitioner on 4/12/16 and a new order which was obtained on 4/25/16 from the wound nurse practitioner were both implemented but staff did not see the order from the orthopedic surgeon.</p> <p>This federal tag is related to complaint IN00200074</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility</p>			

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	<p>must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review, review of hospital records and interview the facility failed to obtain physician orders for a surgical ulcer wound and failed to ensure accurate weekly skin assessments for 1 resident (B) in a sample of 3 resident records reviewed.</p> <p>Findings include:</p> <p>1. On 5/17/16 at 9:00 a.m. review of the clinical record for resident (B) indicated he was admitted to the facility on 4/4/16 with Diagnoses including but not limited to Metastatic Melanoma, Diabetes, Neuropathy, Obesity, Depression, Clostridium Difficile, and Surgical Ulcer of the Left Great Toe.</p> <p>Review of the admission orders dated 4/4/16 indicated "Wound Care-Left great toe and left foot" . There were no physician orders for a treatment to the resident's left great toe.</p> <p>Review of the hospital records for resident (B) on 5/17/16 at 1:00 p.m. indicated the resident had fallen at home and broke his left great toe. Orthopedics</p>	F 0309	<p>Provide care/services for highest well being</p> <p>F 309 Failure to obtain Physician's order for a surgicalulcer wound</p> <p>1.DON or designee to audit new admission's within24 hours of admission for accuracy of physician orders and accuracy ofintegumentary system assessment.</p> <p>2.DON or designee to do a head to toe skinassessment within 24 hours of admission to evaluate the accuracy of admissiondocumentation.</p> <p>3.Re-education to be completed on 6/10/16 with100% of nursing staff regarding the admission process along with second checkprocess with second nurse.</p> <p>4.Re-education completed on 5/18/16 with the woundnurse to ensure following all residents with skin alterations per policy.</p> <p>5.DON or designee to audit 100% skin alterationsfor accuracy of wound assessments daily x7 and then weekly ongoing.</p> <p>6.IDT members to discuss progress/decline duringweekly At Risk meeting. Ensure MD, NP or wound NP is updated with concerns ontimely basis.</p>	06/10/2016

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	<p>had removed the toenail and stitched the area and the resident was then admitted to the facility on 4/4/16.</p> <p>Review of the clinical record for resident (B) on 5/17/16 at 1:15 p.m. indicated the first noted order for a treatment for the resident's toe was 4/12/16 written by the nurse practitioner which indicated "Cleanse left toe with wound waser [sic], pat dry. Hydrogel with gauze, change daily and as needed. Further review of the medical record indicated the "Wound Nurse Practitioner" saw the resident on 4/25/16 and wrote an order to discontinue current order, and gave a new order to "Clean left great toe with wound waser [sic], pat dry, cover with gauze, change daily and as needed."</p> <p>Further review of the clinical record for resident (B) on 5/17/16 at 1:15 p.m. indicated a "Clinical Visit Summary" from the orthopedic physician. Review of the summary indicated "Sutures were removed today on the toe. He should continue to dress the wound with a very thin layer of antibiotic ointment and then a dry nonstick dressing. He should be elevating the legs when in bed, above heart level, on 2-3 pillows to help with swelling."</p> <p>Review of the "April and May 2016</p>			

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	<p>Medication/Treatment Records" did not indicate this order was entered into the computerized treatment records for resident (B) and there was no documentation of the order being followed.</p> <p>Interview on 5/18/16 at 9:00 a.m. with the Corporate Nurse Consultant indicated the nursing staff did not obtain an order for the resident's toe wound until 4/12/16 and did not see the order from the orthopedic surgeon.</p> <p>2. Review of the clinical record for resident (B) on 5/17/16 at 1:45 p.m. indicated he admitted to the facility on 4/4/16 with a surgical wound ulcer of the left great toe.</p> <p>Review of the weekly skin reviews for resident (B) included:</p> <p>4/7/16-Form marked "No skin issues present."</p> <p>4/11/16-Form marked "bruises and redness" but no indication where these areas were.</p> <p>4/18/16- Form marked "redness" but no indication where the redness was.</p> <p>4/20/16-Form marked "No skin issues</p>			

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	<p>present."</p> <p>4/21/16-Form marked "Left Lateral Calf, skin tear, happened in therapy from wheelchair."</p> <p>4/25/16-Form marked "Left Lateral Calf, skin tear, happened in therapy from wheelchair."</p> <p>5/2/16-Form marked "redness, edema" but no indication where these areas were.</p> <p>On 5/18/16 at 9:30 a.m. review of the current facility policy for "Skin Assessments and Evaluations" which was not dated, indicated the following:</p> <p>"If the admission nurse identifies an alteration in resident's skin integrity, the nurse will notify the physician for a treatment order, and document this communication the resident's medical record."</p> <p>This federal tag is related to complaint IN00200074</p> <p>3.1-37(a)</p>			