

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HARBOUR ASSISTED LIVING OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 3110 E COLISEUM BLVD FORT WAYNE, IN 46805
---	---

(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
R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00198069.</p> <p>Complaint IN00198069 - Substantiated with state findings at R0241.</p> <p>Survey Dates: May 9 &amp; 10, 2015</p> <p>Facility number: 010235 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 52 Total: 52</p> <p>Census payor type: Other: 52 Total: 52</p> <p>Sample: 3</p> <p>This state finding is cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on May 11, 2016.</p>	R 0000	The following Plan of Correction, prepared and submitted by The Harbour at Fort Wayne, is not to be construed as an admission of, or agreement with, the findings and conclusions in the Statement of Deficiencies. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to the allegation or finding. We respectfully request a desk review for deficiency cited.	
R 0241  Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HARBOUR ASSISTED LIVING OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 3110 E COLISEUM BLVD FORT WAYNE, IN 46805
---	---

(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 provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to follow physician orders for the administration of insulin and blood sugar monitoring for 1 resident (B) in a sample of 3 resident records reviewed who received insulin and blood sugar monitoring.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident (B) indicated he was admitted to the facility on 12/7/14 with diagnoses including but not limited to Diabetes, Chronic Kidney Disease, and Neuropathy.</p> <p>On 4/9/16 at 10:00 a.m., review of the clinical record indicated a physician's progress note, dated 3/30/16, which indicated "Here for routine DM (diabetes) check up. According to medication list provided by patient, the assisted living facility discontinued his insulin and metformin in December." The physician then wrote an order for Lantus (insulin) 55 units subcutaneous every evening and to check blood sugar</p>	R 0241	<p>R241: 1. The current diabetic resident's medication records have been audited against the current orders for accuracy of any diabetic medications and accu-checks that were ordered from the physician on May 10th, 2016. 2. All other diabetic resident's medication records and orders were reviewed for accuracy. 3. The medication team will be educated by May27th, 2016 by the Regional Director of Health and Wellness on a new 3 way audit that will be conducted on any medication changes presented by a physician. The 3 way audit will be implemented by May 27, 2016 and consist of placing a copy of the order on the medication record, transcribing the order, and faxing the order to the respective delivering pharmacy, and the profiling pharmacy. Health and Wellness Director and/or designee will assure current resident orders are transcribed correctly against the current order from the physician. When the medication arrives the Health and Wellness Director and or designee will assure the medication and its label is accurate against the transcription, the order from the</p>	06/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2016
NAME OF PROVIDER OR SUPPLIER  HARBOUR ASSISTED LIVING OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 3110 E COLISEUM BLVD FORT WAYNE, IN 46805		
(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>daily.</p> <p>Interview with the Assisted Living Director, on 5/9/16 at 10:15 a.m., indicated the resident's daughter had called her and said she had noticed her dad's pharmacy had not been sending his insulin. The Assisted Living Director indicated she had looked at the Medication Administration Record (MAR) and the insulin had been marked off of the record and noted with a discontinue date of 12/31/15. There was also no record of a physician order to discontinue the medication. She then told the resident's daughter she should probably take her father to the physician.</p> <p>Interview with Resident (B) on 5/10/16 at 9:15 a.m. indicated the resident thought he had not been getting insulin for about a month and told his daughter who then took him to the physician. The resident indicated he had been a diabetic and taking insulin for a long time.</p> <p>This state tag is related to complaint IN00198069.</p>		<p>physician, and the medication package. When all correspondence is clarified 3 ways, the copy of the physician order will be removed from the Medication record and placed in binder. This allows for the ease of checks at end of month for any changes. The End of Month Medication record will be checked against the old record and the new record and any corresponding orders from the physician that have been changed. 4. Executive Director, Health and Wellness Director and/or designee will audit 2 times weekly for 3 months, then weekly there after for new orders and transcription to MAR for accuracy. Results to be reviewed by the Quality Assurance Committee on a quarterly basis. 5. 6/3/16</p>		