

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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F000000	<p>This visit was for the Investigation of Complaints IN00134671, and IN00135403.</p> <p>Complaint IN00134671-Substantiated. Federal/state deficiencies related to the allegations are cited at F241, and F282.</p> <p>Complaint IN00135403-Substantiated. Federal/state deficiency related to the allegations is cited at F309.</p> <p>Survey dates: September 3, 4, and 5, 2013</p> <p>Facility number: 000476 Provider number: 155446 AIM number: 100290870</p> <p>Survey team: Christine Fodrea, RN TC</p> <p>Census bed type: SNF/NF: 119 Total: 119</p>	F000000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	

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

TITLE

(X6) DATE

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

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	<p>Census payor type:</p> <p>Medicare: 25</p> <p>Medicaid: 72</p> <p>Other: 22</p> <p>Total: 119</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 6, 2013 by Randy Fry RN.</p>						

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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, and interview, the facility failed to provide clothing protectors in good repair for 1 of 3 residents reviewed wearing clothing protectors at mealtime in a sample of 6. (Resident # A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed 9-4-2013 at 12:25 PM. Resident #A's diagnoses included but were not limited to: edema, osteoarthritis, and diabetes.</p> <p>Resident #A's most recent quarterly Minimum Data Set (MDS) dated 6-23-2013 indicated her Brief Interview for Mental Status (BIMS) score was 13 which indicated Resident #A was interviewable.</p> <p>On 9-3-2013 at 11:50 AM, Resident #A was observed wearing a clothing protector with a 2 inch hole close to the neckline.</p>	F000241	<p>1. Facility to dispose of all clothing protectors that have tears/holes in them. Social Services/designee approached the Resident Council President and had him choose which clothing protectors the facility will purchase. 2. Staff to be educated in an in-service on Septmeber 17. All residents have the potential to be affected. Residents were informed that the facility would be purchasing new clothing protectors . If any clothing protectors found by staff or residents that are tattered or have holes, they will be replaced with an adequate protector. 3. Dietary/Laundry or designee to monitor clothing protectors to ensure they are not tattered nor have holes. 4. Rounds will be completed twice a month to ensure the clothing protectors are not tattered nor have any holes in them. These forms will be turned into the Admin/designee and be reviewed monthly in QA and quarterly by the Medical Director for six months. 5. Facility will be compliant by September 25, 2013</p>	09/25/2013

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	<p>In an interview on 9-3-2013 at 2:11 PM, Resident #A indicated tattered clothing protectors were a problem, and if anyone needed a clothing protector, they would have to wear one that had holes or was tattered.</p> <p>In an interview on 9-3-2013 at 11:52 AM, CNA #1 indicated most of the clothing protectors were tattered and had holes. CNA #1 further indicated sometimes it was necessary to use the tattered clothing protectors because no others were available.</p> <p>On 9-4-2013 at 8:11 AM, Resident #A was observed in the main dining room eating breakfast. Resident #A was wearing a clothing protector with 4 holes around the edges. Each hole was about 1 inch in diameter.</p> <p>In an interview on 9-4-2013 at 1:30 PM, the Administrator indicated he was unaware of the clothing protectors needing repair, but he would order new ones immediately.</p> <p>This Federal tag relates to Complaint IN00134671.</p> <p>3.1-3(t)</p>						

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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 interview and record review, the facility failed to follow physician's orders for medication administration for 1 of 3 residents reviewed for medication administration in a sample of 6. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed 9-4-2013 at 12:25 PM. Resident #A's diagnoses included but were not limited to: edema, osteoarthritis, and diabetes.</p> <p>A physician's order dated 8-30-2013 indicated Resident #A's Coumadin (a blood thinner) was to be decreased from 5 milligrams (mg) daily to 4 mg daily on 9-2-2013.</p> <p>A review of the Medication Administration Record (MAR) dated 9-2013 indicated Resident #A was receiving Coumadin 4 mg daily on 9-2, and 9-3. Additionally, on a separate sheet in Resident #A's MAR</p>	F000282	<p>1. The facility will follow physician orders for medications and be transcribed on the MAR appropriately. Resident #A's Coumadin orders and MAR were updated according to the Physician Orders.2. Staff to be educated in an in-service on Septmeber 17. .Facility reviewed all residents with Coumadin orders for all residents on coumadin to ensure that the logs coincide with the Physician Orders. There were no other errors found.3. Licensed personnel educated to ensure they are transcribing the coumadin orders onto the log. Director of Nursing/designee will review Coumadin orders 5x/week for 1 month, weekly for 2 months and monthly for 3 months to ensure Coumadin orders are complied with. 4. Results will be forwarded to the QA committee monthly for two months and then quarterly for 6 months after. Forms will be turned into the Director of Nursing/designee and be reviewed monthly in QA and quarterly by the Medical Director for six months. 5. Facility will be compliant by September 25, 2013</p>	09/25/2013			

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	<p>dated 9-2013, Resident #A was receiving an additional Coumadin 1 mg daily on 9-2 and 9-3.</p> <p>In an interview on 9-4-2013 at 1:10 PM, the Director of Nursing indicated Resident #A should have received her Coumadin as ordered by the physician.</p> <p>This Federal tag relates to Complaint IN00134671.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to adequately assess skin under a splint for 1 of 3 residents (Resident #D); and failed to assess bowel status for 1 of 3 residents (Resident #F) reviewed for assessment in a sample of 6.</p> <p>Findings include:</p> <p>1. Resident #D's record was reviewed 9-3-2013 at 2:34 PM. Resident #D's diagnoses included but were not limited to depression, insomnia, and cellulitis.</p> <p>A note on Resident #D's Medication Administration Record (MAR) dated 8-22-2013 indicated to check skin, pulse and extremity color every day. The MAR indicated the checks were completed on 8-23, 24, 25, 26, and 27. There was no indication the checks were completed after 8-27-2013.</p> <p>A review of Resident #D's MAR dated</p>	F000309	<p>1. The facility will monitor those residents that have appliances that can cause skin breakdown. The facility will monitor BM's on a nightly basis and assess bowel sounds as needed for those residents that are having periods of constipation or diarrhea. 2. Staff to be educated in an in-service on Septmeber 17. All residents with appliances were assessed and found to have no skin breakdown. Residents with appliances were added to pertinent charting to complete daily assessment of skin, pulses, color and edema. No other residents were affected. All residents BM's were audited and modalities put in place along with assessments of bowel sounds. No other residents were found to be affected by the deficiency. 3. All residents with appliances will be added to 24 hour report for pertinent charting and assessment. The 24 hour report and pertinent charting is auditted by UM/designee 5x/week. BM's/ADL's will be printed off by 3rd shift and monitorred to assure all residents have had a BM</p>	09/25/2013			

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	<p>9-2013 did not indicate the checks were completed.</p> <p>A review of nurse's notes indicated no mention of the skin checks after 8-27-2013.</p> <p>In an interview on 9-3-2013 at 3:47 PM, the Administrator indicated the skin, pulse and color should have been assessed daily as indicated on the MAR.</p> <p>2. Resident #F's record was reviewed 9-4-2013 at 9:07 AM. Resident #F's diagnoses included but were not limited to fibromyalgia, history of bowel obstruction, and diabetes.</p> <p>A Nurse's note dated 8-18-2013 at 3:25 PM indicated Resident #F had not had a bowel movement since Tuesday (8-13). The physician was notified and orders were received.</p> <p>A review of Resident #F's bowel tracking sheet indicated Resident #F had a medium bowel movement 8-13-2013 at 12 noon. The tracking sheet indicated there was no further bowel movement until after a suppository was administered on 8-18-2013 yielding large results.</p> <p>A review of the Nurse's notes</p>		<p>within 72 hours. Assessment of bowel sounds to be completed, Doctor to be notified and any new orders to be processed. 4. UM/Designee will monitor all BM documentation to assure all residents have been assessed, doctor notified and any physician's order processed. Results will be forwarded to the QA committee monthly for two months and then quarterly for 6 months after. Forms will be turned into the Director of Nursing/designee and be reviewed monthly in QA and quarterly by the Medical Director for six months. 5. Facility will be compliant by September 25, 2013</p>				

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	<p>between 8-13 and 8-18-2013 did not indicate bowel sounds were checked, or abdomen was checked for tightness.</p> <p>In an interview on 9-4-2013 at 11:19 AM, Resident #F indicated she had told staff she was constipated, but no one looked at her belly or did anything.</p> <p>In an interview on 9-4-2013 at 11:22 AM, LPN #2 indicated someone should have assessed Resident #F's bowel sounds and belly characteristics.</p> <p>This Federal tag relates to Complaint IN00135403.</p> <p>3.1-37(a)</p>				