

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155654	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/05/2013
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NAME OF PROVIDER OR SUPPLIER  ENGLEWOOD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE RD FORT WAYNE, IN 46809
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F000000	<p>This visit was for the Investigation of Complaint IN00124980.</p> <p>Complaint IN00124980-Substantiated. Federal/state deficiencies related to the allegations are cited at F241 and F323.</p> <p>Survey dates: February 4 and 5, 2013</p> <p>Facility number: 000498 Provider number: 155654 AIM number: 100266110</p> <p>Survey team: Christine Fodrea, RN TC</p> <p>Census bed type: SNF/NF: 58 Total: 58</p> <p>Census payor type: Medicare: 6 Medicaid: 41 Other: 11 Total: 58</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p><i>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.</i></p>	
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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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	Quality Review completed on March 6, 2013 by Randy Fry RN.			

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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, interview, and record review, the facility failed to ensure a female resident was kept from view of a male resident while using the restroom for 1 of 3 residents reviewed for privacy in a sample of 3.</p> <p>Findings include:</p> <p>Resident #B's record was reviewed 3-4-2013 at 11:15 AM. Resident #B's diagnoses included, but were not limited to, dementia with behavioral disturbances, depression, and osteoporosis.</p> <p>A behavior note dated 2-18-2013 indicated Resident #B was yelling and screaming at another resident. The note further indicated Resident #B was noted in the bathroom while the other resident stood in the bathroom doorway.</p> <p>A Minimum Data Set dated 2-21-2013 indicated Resident #B had a BIMS (Brief Inventory of Mental Status) score of 5.</p>	F000241	<ol style="list-style-type: none"> <li>Both residents' involved were moved to different rooms shortly after incident occurred.</li> <li>All current residents with adjoining bathrooms have been reviewed for compatibility. Criteria for determining incompatibilities shall be determined by the following: behaviors related to bathroom usage, grievances expressed by resident/family member or concerns voiced during satisfaction interviews. Potential resident relocation to occur should any of the preceding occur. No further concerns.</li> <li>Facility Interdisciplinary team shall review all future behaviors related to conjoined bathrooms for a potential resident relocation. Resident and family satisfaction surveys shall be completed quarterly.</li> <li>Social Services/Designee shall monitor for triggered behaviors/grievances 4 times per week for 4 weeks, 2 times per week for 4 weeks, then monthly in behavior management review ongoing. Results shall be forwarded to Quality Assurance Committee Meeting until full compliance is</li> </ol>	03/22/2013			

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	<p>In a confidential interview, on 3-4-2013 at 10:34 AM, a family member indicated Resident #B was in a room that shared a bathroom with the room next to it. The family member further indicated women were in the room nearest the nurse's desk with men in the room adjoining.</p> <p>In an observation of resident rooms, the room Resident #B had been assigned on 2-18-2013 shared a bathroom with the room next door. Female residents were observed in both rooms. Informational signs had been posted on both doors reminding all of the need to knock on the bathroom door as the bathroom was utilized by both male and female residents.</p> <p>In an interview on 3-4-2013 at 2:14 PM, CNA #1 indicated she was on duty on 2-18-2013 and had been assigned to float between halls. CNA #1 indicated she heard Resident #B call out. CNA #1 indicated she went into Resident #B's room a male resident was found in the bathroom doorway. CNA #1 further indicated Resident #B was not wearing clothing at the time of the incident.</p> <p>In an interview on 3-4-2013 at 2:39</p>		<p>achieved. Interdisciplinary team shall complete resident and family satisfaction interviews at minimum quarterly. Findings within these interviews shall also be reviewed and evaluated during Quality Assurance Committee Meetings until full compliance is achieved.</p>				

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	<p>PM, LPN #2 indicated when she went to the assistance of Resident #B during the 2-18-2013 incident, LPN #2 indicated Resident #B was in the bathroom in her underclothing, but had no outer clothing on.</p> <p>In an interview on 3-4-2013 at 2:49 PM, CNA #3 indicated Resident #B liked to primp in the bathroom. she further indicated a male resident in the room next door was upset by her primping in the bathroom and more than once opened the bathroom door to yell at her. CNA #3 further indicated the male resident did not follow the knock first signs and would yell at Resident #B whether she was dressed or not.</p> <p>In an interview on 3-5-2013 at 9:30 AM, LPN #4 indicated she felt Resident #B's repeated interruption by a resident of the opposite sex in the bathroom was a dignity issue.</p> <p>This Federal tag relates to Complaint IN00124890.</p> <p>3.1-3(t)</p>						

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based interview and record review, the facility failed to prevent a verbal confrontation between residents for 1 of 3 residents reviewed in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed 3-4-2013 at 11:15 AM. Resident #B's diagnoses included, but were not limited to, dementia with behavioral disturbances, depression, and osteoporosis.</p> <p>A behavior note dated 2-18-2013 indicated Resident #B was yelling and screaming at another resident. The note further indicated Resident #B was noted in the bathroom while the other resident stood in the bathroom doorway.</p> <p>In a confidential interview, on 3-4-2013 at 10:34 AM, a family member indicated Resident #B was intimidated by the man in the room</p>	F000323	<ol style="list-style-type: none"> <li>Both residents' involved were moved to different rooms shortly after incident occurred.</li> <li>All current residents with adjoining bathrooms have been reviewed for compatibility. Criteria for determining incompatibilities shall be determined by the following: behaviors related to bathroom usage, grievances expressed by resident/family member or concerns voiced during satisfaction interviews. Potential resident relocation to occur should any of the preceding occur. No further concerns.</li> <li>Facility Interdisciplinary team shall review all future behaviors related to conjoined bathrooms for a potential resident relocation. Resident and family satisfaction surveys shall be completed quarterly.</li> <li>Social Services/Designee shall monitor for triggered behaviors/grievances 4 times per week for 4 weeks, 2 times per week for 4 weeks, then monthly in behavior management review ongoing. Results shall be forwarded to Quality Assurance Committee Meeting until full compliance is</li> </ol>	03/22/2013

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	<p>adjacent to hers due to a disagreement over the bathroom. The family member further indicated the rooms shared a bathroom and the man in the room next to hers yelled at her.</p> <p>In an observation of resident rooms, the room Resident #B had been assigned on 2-18-2013 shared a bathroom with the room next door. Female residents were observed in both rooms.</p> <p>In an interview on 3-4-2013 at 2:14 PM, CNA #1 indicated she was on duty on 2-18-2013 and had been assigned to float between halls. CNA #1 indicated she heard Resident #B call out. CNA #1 indicated she went into Resident #B's room a male resident was found in the bathroom doorway yelling at Resident #B. CNA #1 indicated she called for help and the nurse came to assist her.</p> <p>In an interview on 3-4-2013 at 2:39 PM, LPN #2 indicated when she went to the assistance of Resident #B during the 2-18-2013 incident, LPN #2 indicated Resident #B was in the bathroom under the sink, curled up, and was yelling at a male resident who was standing in the doorway. The male resident was yelling at</p>		<p>achieved. Interdisciplinary team shall complete resident and family satisfaction interviews at minimum quarterly. Findings within these interviews shall also be reviewed and evaluated during Quality Assurance Committee Meetings until full compliance is achieved.</p>		

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	<p><b>Resident #B.</b></p> <p>In an interview on 3-4-2013 at 2:49 PM, CNA #3 indicated Resident #B liked to primp in the bathroom. she further indicated a male resident in the room next door was upset by her primping in the bathroom and more than once opened the bathroom door to yell at her. CNA #3 further indicated the male resident did not follow the knock first signs and would yell at Resident #B whether she was dressed or not.</p> <p>A Social services note dated 2-18-2013 indicated Resident #B was moved to a room down the hall away from the male resident.</p> <p>A policy titled abuse dated 10-2005 provided by the Administrator on 3-5-2013 indicated under purpose..." the policy's purpose is to ensure that resident rights were protected ..."</p> <p>This Federal tag relates to Complaint IN00124890.</p> <p>3.1-45(a)(2)</p>						