

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 08/06/2014
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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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F000000	<p>This visit was for the Investigation of Complaint IN00153765 and IN00153825.</p> <p>Complaint IN00153765- Substantiated, deficiencies are cited at F-280 and F-329. Complaint IN00153825-Unsubstantiated, due to lack of evidence.</p> <p>Survey Dates: August 4, 5 & 6, 2014</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 5 Medicaid: 57 Other: 14 Total: 76</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</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.

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F000280 SS=D	<p>Quality review completed on August 8, 2014 by Randy Fry RN.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview the facility failed to develop and implement a written plan of care for the use of a short acting anti-anxiety medication which addressed non-pharmacological interventions to be implemented prior to the use of the medication for 1 resident (A) in a sample of 3 resident records</p>	F000280	<p>RESIDENT a WAS DISCHARGED ON 7-10-14</p> <p>Care plans on all residents receiving anti-anxiety medications have been reviewed and updated. Residents receiving anti-anxiety medications are reviewed monthly in the behavior meeting.</p> <p>Nurses are being in-serviced on updating care plans when physicians</p>	08/29/2014

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	<p>reviewed.</p> <p>Finding includes:</p> <p>On 8/4/14 at 2:00 p.m. review of the clinical record for resident (A) indicated he was admitted to the facility with diagnoses including but not limited to Alzheimer's Dementia, Dysphagia and Muscle Weakness.</p> <p>Review of the clinical record indicated on 6/20/14 the resident fell out of his wheelchair and struck his right upper forehead. The resident was sent to the emergency room and returned to the facility with a diagnosis of a large scalp hematoma overlying the right frontal bone with no underlying skull fracture identified.</p> <p>Review of physician orders dated 6/22/14, indicated the resident was having increased pain and increased agitation and anxiety. The physician ordered Tramadol (pain reliever) 100 milligrams per mouth every 4 hours as needed for pain and Ativan (anti-anxiety medication) 0.5 milligrams per mouth every 4 hours as needed for agitation and anxiety.</p> <p>Review of the medication administration records for June and July, 2014 indicated</p>		<p>order prn anti-anxiety medications. Care plan in-service will completed by 8-27-14.</p> <p>Resident receiving prn anti-anxiety medications have had their care plans updated. Residents receiving new orders for prn anti-anxiety medications will have their care plans updated at the time of the order.</p> <p>New orders are reviewed daily (Monday to Friday) in the nursing meeting. Any resident receiving new orders for prn anti-anxiety medications will have their care plan updated. Care plans will be reviewed from the new orders and the results reported to the QA committee meeting monthly ongoing by the MDSC.</p> <p>8.29.14</p>		

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	<p>the resident was given the Ativan 9 times between 6/22 and 7/6/14. The Tramadol was only given 2 times which occurred on 6/23/14. A Dose of Tylenol (pain reliever) 650 milligrams was noted to be given to the resident on 7/5/14. Review of the clinical record did not indicate any documentation of staff attempting implementation of a non-pharmacological intervention to relieve the resident's agitation and anxiety prior to giving the "as needed dose of Ativan."</p> <p>Interview with the Administrator on 8/6/14 at 8:40 a.m. indicated he had reviewed the clinical record and could not find any documentation of non-pharmacological interventions used for this resident prior to the use of the Ativan. Further interview with the administrator indicated there was not a written plan of care in resident (A's) clinical record which addressed the use of the Ativan or non-pharmacological interventions in his plan of care which could be used in an attempt to relieve his anxiety and agitation prior to the use of the "as needed" Ativan order.</p> <p>This federal tag is related to complaint IN00153765</p>			

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F000329 SS=D	<p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to implement non-pharmacological interventions prior to the use of an anti-anxiety medication for 1 resident (A) in a sample of 3 resident records reviewed.</p> <p>Finding includes:</p>	F000329	<p>Resident A was discharged on 7.10.14. Behavior Interventions Monthly Flow Records have been started on all residents receiving anti-anxiety medications. Nurses will be in-serviced on using the new behavior intervention flow sheets, which documents non</p>	08/29/2014			

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