

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  10/07/2014
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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 IN00156011.</p> <p>Complaint IN00156011 Substantiated. Deficiencies related to the allegations are cited at F 225, F 226, and F 514.</p> <p>Survey dates: October 6, and 7, 2014</p> <p>Facility number : 000153 Provider number: 155249 AIM number: 100266910</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 5 Medicaid: 61 Other: 16 Total: 82</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with</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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F000225 SS=D	<p>410 IAC 16.2-3.1.</p> <p>Quality review completed on October 8, 2014 by Randy Fry RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>			

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	<p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report a bruise of unknown origin to the state regulatory agency for 1 of 3 residents reviewed with bruising in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>1. Resident #A's record was reviewed 10-6-2014 at 10:45 AM. Resident #A's diagnoses included but were not limited to above knee amputation on the left, high blood pressure, and depression.</p> <p>Resident #A's Nurse's note dated 9-7-2014 at 1200 PM (noon) indicated Resident #A had a discoloration on her right leg that was firm to touch. The size of the discoloration was not noted on the note.</p> <p>A review of Resident #A's SBAR report dated 9-7-2014 at 9:45 PM indicated Resident #A could not say what happened. There was no indication of the</p>	F000225	<p>It is the intent of this facility to assure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported to the administrator of the facility and other officials in accordance with State law through established procedures. Resident A is alert and oriented times 3. Resident A's bruise was a complication from having a dislocated hip and ASA therapy. Resident A has a history of spontaneous dislocations of the right hip. When the resident complained her hip was bothering her and a bruise was noted the NP was notified and an order for x-ray was given. The report showed the hip to be dislocated. (See attachments) The bruise was not reported because the resident has a history of spontaneous hip dislocation, which was verified by x-ray. The resident did not know why her hip dislocated but the resident has never known why her hip dislocates.</p> <p>1. Resident A's bruise was due</p>	10/24/2014

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	<p>size of the bruising on the SBAR report.</p> <p>A review of the facility to hospital transfer form dated 9-7-2014 did not indicate the size of the bruising.</p> <p>In an interview on 10-7-2014 at 8:38 AM, LPN #1 indicated she had assessed the bruised area on 9-7-2014 at about noon. The bruising was dark purple, and extended from hip to knee on the right. LPN #1 further indicated at the time, Resident #A was on Aspirin therapy, and transferred with two assist, pivoting on the right leg. She further indicated Resident #A had been transferred to her wheelchair at about 10 AM without incident. At about 12 noon, Resident #A began complaining of right hip pain. LPN #1 further indicated lack of documentation of the extent of the bruising was an oversight. LPN #1 indicated she did not tell anyone of the extent of the bruising, but it was noted on the incident report.</p> <p>In an interview on 10-7-2014 at 8:59 AM, the Director of Nursing indicated the facility did not have specific guidelines about reporting bruising of unknown origin, but LPN #1 should have notified her supervisor for follow up.</p> <p>This Federal citation is related to</p>		<p>to a dislocated hip and ASA therapy. If resident has any further bruising the facility will report at the time bruise is noted.</p> <p>2.No other residents have been identified. If any resident with a bruise of unknown origin or greater than 7.5cm will be reported to ISDH.</p> <p>3.Nurses were in-serviced on 10-22-14 and C.N.A.'s were in-serviced on 10-23-14 on reporting bruises to the DON and Administrator. Nurses will do a weekly skin check on all residents. If any bruises are noted they will be measured and reported to DON and Administrator. DON or designee will track bruises and assure that any bruise meeting the criteria to be reported is report to ISDH.</p> <p>4.DON will report to the QA committee monthly any bruises that meet the criteria along with the report to the ISDH. This will be monthly, ongoing.</p> <p>5.10-24-14</p>		

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F000226 SS=D	<p>complaint IN00156011.</p> <p>3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow their policy for reporting a bruise of unknown origin for 1 of 3 residents reviewed with bruising in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>1. Resident #A's record was reviewed 10-6-2014 at 10:45 AM. Resident #A's diagnoses included but were not limited to above knee amputation on the left, high blood pressure, and depression.</p> <p>Resident #A's Nurse's note dated 9-7-2014 at 1200 PM (noon) indicated Resident #A had a discoloration on her right leg that was firm to touch. The size of the discoloration was not noted on the note.</p>	F000226	<p>F226</p> <p>It is the intent of this facility to assure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported to the administrator of the facility and other officials in accordance with State law through established procedures.</p> <p>1. The bruise in question to resident A has resolved and no further bruising is found. 2. Although all residents have the potential to be effected, no other residents have been identified. If any resident presents with a bruise the meets criteria according to the policy and procedure for reporting, the bruise will be reported to ISDH as soon as possible. 3. Director of Nursing was in-serviced regarding the facilities</p>	10/24/2014

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	<p>A review of Resident #A's SBAR report dated 9-7-2014 at 9:45 PM indicated Resident #A could not say what happened. There was no indication of the size of the bruising on the SBAR report.</p> <p>A review of the facility to hospital transfer form dated 9-7-2014 did not indicate the size of the bruising.</p> <p>In an interview on 10-7-2014 at 8:38 AM, LPN #1 indicated she had assessed the bruised area on 9-7-2014 at about noon. The bruising was dark purple, and extended from hip to knee on the right. LPN #1 further indicated at the time, Resident #A was on Aspirin therapy, and transferred with two assist, pivoting on the right leg. She further indicated Resident #A had been transferred to her wheelchair at about 10 AM without incident. At about 12 noon, Resident #A began complaining of right hip pain. LPN #1 further indicated lack of documentation of the extent of the bruising was an oversight. LPN #1 indicated she did not tell anyone of the extent of the bruising, but it was noted on the incident report.</p> <p>In an interview on 10-7-2014 at 8:59 AM, the Director of Nursing indicated the facility did not have specific</p>		<p>policy and procedure for reporting injuries to residents on 10.07.2014. Licensed Nurses were in-serviced regarding Reportable Incidents on 10-22-14 and Certified Nursing Assistants were in-serviced on 10-23-14 regarding reporting bruises to the DON and Administrator.</p> <p>4. During new employee orientation of nursing staff the policy regarding reporting bruises will be reviewed. Human Resources will review and verify to that all new nursing staff have reviewed and signed validating understanding on the reportable incidents policy on an ongoing basis. DON and/or designee to monitor 24 hour shift report book to assure that any bruising is evaluated and appropriate steps followed 5 times weekly for 4 weeks. All findings will be discussed in the QA meeting monthly X 3 and then quarterly thereafter until substantial compliance is achieved.</p> <p>5. The CEO to assure compliance 10-24-14</p>	

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F000514 SS=D	<p>guidelines about reporting bruising of unknown origin, but LPN #1 should have notified her supervisor for follow up.</p> <p>This Federal citation is related to complaint IN00156011.</p> <p>3.1-28(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to follow their policy regarding hospital transfer documentation for 2 of 3 residents reviewed for hospital transfer documentation in a sample of 3. (Resident #A and Resident #B)</p> <p>Findings include:</p>	F000514	<p>F 514 It is the intentof the facility to maintain clinical records on each resident in accordancewith accepted professionalstandards and practices that are complete; accurately documented; readilyaccessible; and systematically organized.</p>	10/24/2014

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	<p>1. Resident #A's record was reviewed 10-6-2014 at 10:45 AM. Resident #A's diagnoses included but were not limited to above knee amputation on the left, high blood pressure, and depression.</p> <p>A physician's order dated 9-7-2014 indicated to send Resident #A to the hospital for evaluation and treatment of right leg pain and dislocation.</p> <p>A review of Resident #A's transfer documentation included a Discharge to hospital Checklist.</p> <p>A review of the Discharge to Hospital Checklist indicated "3. Copy the following documents (2 copies - one to send with the resident, one to include with discharge packet and stays on the chart). a. Medication Administration records/Treatment Administration (MAR/TAR) records b. Physician Order Sheets (POS)- most current month and all telephone orders received since last signed POS c. any Advance Directive on chart d. face sheet."</p> <p>A review of Resident #A's discharge packet available on the active chart, and overflow chart indicated there were no copies of the current MAR/TAR, POS, telephone orders, advance directives, or face sheets copied to keep with the</p>		<p>1.Nothing can be done for resident's A and B as they have returned to the facility.</p> <p>2.Anyresident that were sent out to the hospital prior to 10-8-14 had the potentialto be affected. Nothing can be done atthis time for residents previously sent out to the hospital.</p> <p>3.Nurseswere in-serviced on 10-8-14 regarding the policy for what documents must besent on resident transfers to the hospital. Medical records will review all charts of residents transferred to thehospital to assure all documents required are on the chart.</p> <p>4.Medicalrecords will report to the QA committee monthly. All findings will be discussed in the QAmeeeting monthly X 3 and then quarterly thereafter until substantial complianc eis achieved.</p> <p>5.10-24-14</p>				

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	<p>transfer file at the facility.</p> <p>In an interview on 10-7-2014 at 9:22 AM, LPN #2 indicated the documents that accompanied the resident should have been copied for the transfer file. LPN #2 further indicated the record was incomplete.</p> <p>2. Resident #B's record was reviewed 10-7-2014 at 9:10 AM. Resident #B's diagnoses included, but were not limited to bipolar disorder, high blood pressure, and depression.</p> <p>A physician's order dated 7-19-2014 indicated to send Resident #B to the hospital for evaluation and treatment for high temperature, and cough.</p> <p>A review of Resident #B's discharge packet available on the active and overflow charts, indicated there were no copies of the current MAR/TAR, POS, telephone order, advance directives, or face sheet copied to keep with the transfer file on the chart.</p> <p>This Federal citation is related to complaint IN00156011.</p> <p>3.1-50(a)(1)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2014

FORM APPROVED

OMB NO. 0938-0391

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