

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
--	---	--	---

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
R000000	<p>This visit was for the Investigation of Complaint IN00139369.</p> <p>Complaint IN 00139369 Substantiated. State deficiencies related to the allegations are cited at R0036, R0241, and R0349.</p> <p>Survey dates: November 12, 2013</p> <p>Facility number: 010235 Provider number: 010235 AIM number: NA</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: Residential: 61 Total: 61</p> <p>Census payor type: Other: 61 Total: 61</p> <p>Sample: 3</p> <p>These State findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 13, 2013 by Randy Fry RN.</p>	R000000	<p>The following Plan of Correction is prepared and submitted by Harbour of Fort Wayne as mandated by the Indiana State Department of Health. However this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies . Harbour of Fort Wayne maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations.</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 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
--	---	--	---

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
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			
R000036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on interview and record review the facility failed to ensure the physician and family were notified of changes in a wound for 1 of 3 residents reviewed for family and physician notification in a sample of 3. (Resident #U)</p> <p>Findings include:</p> <p>Resident #U's record was reviewed 11-12-2013 at 11:24 AM. Resident #U's diagnoses included but were not limited to: Alzheimer's Dementia, osteoporosis, and anxiety.</p> <p>Resident #U's Hospice notes dated 10-22-2013 indicated Resident #U had a wound on the right buttock measuring 6.1 centimeters (cm) x 5.8 cm x 0.1 cm. The note further indicated the area had no drainage, and no tunneling.</p>	R000036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:(1) a significant decline in the resident 's physical, mental, or psychosocial status; or(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Resident U is no longer living at the community. Residents with a change in condition have the potential to be affected. No other residents were found to be affected. All Licensed Nursing staff will be inserviced before November 28, 2013 on notification of physician and family of change in condition. See the attached policy. A Licensed Nurse shall notify physician and family upon changes of condition in accordance with the policy and</p>	12/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
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>Resident #U's Hospice notes dated 10-30-2013 indicated Resident #U's area on the right buttock now measured 3.8 cm x 4 cm x 0.3 cm. The note further indicated the area had drainage, and tunneling.</p> <p>A fax transmittal dated 11-12-2013 at 1:26 PM did not indicate the physician had been notified of the change in the area on 10-30-2013. Additionally, there was no documentation either in Hospice notes, or facility nursing notes to indicate the family had been notified of the change in the area.</p> <p>In an interview on 11-12-2013 at 1:42 PM, the Administrator indicated the physician and family should have been notified of the change in the area.</p> <p>This State tag relates to Complaint IN00139369.</p>		<p>Indiana state regulations. The Administrator will audit charts for change of condition notification of physician and family weekly for four weeks, then monthly beginning November 23, 2013. Findings will presented to the QA committee by the Administrator for further follow up as indicated during regularly scheduled Quality Assurance Meetings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
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			
R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and 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 interview and record review the facility failed to ensure wound care was completed as ordered for 1 of 3 residents reviewed with wound care in a sample of 3. (Resident #U)</p> <p>Findings include:</p> <p>Resident #U's record was reviewed 11-12-2013 at 11:24 AM. Resident #U's diagnoses included but were not limited to: Alzheimer's Dementia, osteoporosis, and anxiety.</p> <p>Resident #U's Hospice notes dated 10-8-2013 indicated a nonblanchable area 0.5 cm x 0.5 cm x 0 depth was observed on Resident #U's right buttock. Under wound care provided, the note indicated Riley's cream was used three times per day and as needed after each incontinent episode.</p> <p>A review of the physician's telephone order sheets did not indicate an order had been written for the Riley's</p>	R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense(e) The administration of medications and 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:Medication shall be administered by licensed nursing personnel or qualified medication aides. Resident U is no longer living at the community. Residents receiving wound care have the potential to be affected. No other residents were found to be affected. Nursing staff shall be inserviced November 27, 2013 on wound care policy See attached policy, monitoring of hospice visits, and taking and transcribing a physician order. Physician orders shall be signed prior to being implemented by the authorized prescriber. Generic substitutions shall be noted on the prescription or written order. The facility will initiate documentation requirements of hospice and outside provider visits, services rendered during the visit, notifications made and</p>	12/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
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>Cream.</p> <p>A review of the Treatment Administration Record (TAR) indicated Calmoseptine ointment was used three times a day during the time period of 10-1 through 10-30. Although Riley's cream was entered on the TAR, there was no indication it was used or ordered.</p> <p>Resident #U's Hospice notes on 10-17-2013 indicated the area on the right buttock measured 2.9 cm x 2 cm x 0.1 cm. The note further indicated the wound care provided was duoderm to be changed every 3 days, and as needed for soilage.</p> <p>A review of physician's telephone order sheets did not indicate an order had been written for the duoderm.</p> <p>Resident #U's Hospice notes dated 10-22-2013 indicated Resident #U had an area on the right buttock measuring 6.1 centimeters (cm) x 5.8 cm x 0.1 cm. The note further indicated the area had no drainage, and no tunneling.</p> <p>Resident #U's Hospice notes dated 10-30-2013 indicated Resident #U's area on the right buttock now measured 3.8 cm x 4 cm x 0.3 cm.</p>		<p>report given to facility nurse with an emphasis on changes in condition. Hospice shall supply notes for each visit at the time of exit and report off to facility nurse. Hospice notes shall be reviewed weekly by the Assisted Living Director/licensed nurse designee, and updates shall be added to the service plan and communicated to the resident, family and physician as necessary. The Administrator will audit the hospice notes weekly for four weeks and then monthly. Findings will presented to the QA committee by the Administrator for further follow up as indicated during regularly scheduled Quality Assurance Meetings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
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 note further indicated the area had drainage, and tunneling.</p> <p>A review of Resident #U's TAR dated 10-2013 did not include Duoderm in the list of treatments.</p> <p>According to the Hospice notes, the Duoderm should have been replaced every 3 days. The Duoderm should have been replaced on 10-17, 10-20, 10-23, 10-26, and 10-29. Hospice notes indicated the Duoderm had been changed only on 10-17, 10-22, and 10-30, a 5 day and 8 day change respectively.</p> <p>In an interview on 11-12-2013 at 2:10 PM, LPN #1 indicated the Hospice nurse should have written the order and changed the treatments as they were ordered.</p> <p>In an interview on 11-12-2013 at 1:42 PM, the Administrator indicated when Hospice gets an order from the physician, they are to write the order on the telephone order sheets, and the order is transposed to the TAR. The facility then monitors the treatments to be sure they have been completed as ordered. The Administrator further indicated she was unable to find any other documentation the Duoderm had</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013
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>been changed.</p> <p>This State tag relates to Complaint IN 00139369.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
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			
R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review the facility failed to ensure physician's telephone orders were transposed on to the facility chart for 1 of 3 residents reviewed for complete records ion a sample of 3 (Resident #U)</p> <p>Findings include:</p> <p>Resident #U's record was reviewed 11-12-2013 at 11:24 AM. Resident #U's diagnoses included but were not limited to: Alzheimer's Dementia, osteoporosis, and anxiety.</p> <p>Resident #U's Hospice notes dated 10-8-2013 indicated a nonblanchable area 0.5 cm x 0.5 cm x 0 depth was observed on Resident #U's right buttock. Under wound care provided, the note indicated Riley's cream was used three times per day and as needed after each incontinent episode.</p>	R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records -Noncompliance(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:(1) Complete.(2) Accurately documented.(3) Readily accessible.(4) Systematically organized. Resident U no longer resides in the community. Residents with physician orders have the potential to be affected. Nursing staff will be inserviced on November 27, 2013 on receiving and transcribing signed physician orders to the residents MAR and TAR. A licensed nurse will review the written and signed orders from the providers as necessary, then will audit the resident record to ensure orders are present and transcribed accurately to the appropriate medical record. The</p>	12/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013	
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>A review of the physician's telephone order sheets did not indicate an order had been written for the Riley's Cream.</p> <p>Resident #U's Hospice notes on 10-17-2013 indicated the area on the right buttock measured 2.9 cm x 2 cm x 0.1 cm. The note further indicated wound care provided was duoderm to be changed every 3 days, and as needed for soilage.</p> <p>A review of physician's telephone order sheets did not indicate an order had been written for the duoderm.</p> <p>In an interview on 11-12-2013 at 2:10 PM, LPN #1 indicated the Hospice nurse should have written the order if that's what the physician wanted.</p> <p>In an interview on 11-12-2013 at 1:42 PM, the Administrator indicated when Hospice gets an order from the physician, they are to write the order on the telephone order sheets, and the order is transposed to the TAR.</p> <p>This State tag relates to Complaint IN 00139369.</p>		<p>Administrator shall audit the resident files with new orders weekly for four weeks, then monthly . Findings will presented to the QA committee by the Administrator for further follow up as indicated during regularly scheduled Quality Assurance Meetings.</p>				

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

PRINTED: 11/27/2013

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/12/2013
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	