

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--	---	---	---

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
--------------------	--	---------------	---	----------------------

R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00188375.</p> <p>Complaint IN00188375 Substantiated. Deficiencies related to the allegations are cited at R0053, R0306, and R0349</p> <p>Survey dates: December 16, and 17, 2015</p> <p>Facility number: 010235 Provider number: 010235 AIM number: NA</p> <p>Census bed type: Residential: 57 Total: 57</p> <p>Census payor type: Other: 57 Total: 57</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed on December 18, 2015 by 17934.</p>	R 0000		
------------------------	--	--------	--	--

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 <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--	---	---	---

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
R 0053 Bldg. 00	<p>410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse.</p> <p>Based on interview and record review, the facility failed to ensure residents were free from verbal abuse for 1 of 3 residents reviewed for verbal abuse in a sample of 7 (Resident #L)</p> <p>Findings include:</p> <p>Resident #L's record was reviewed 12-17-2015 at 11:20 AM. Resident #L's diagnoses included, but were not limited to, osteoporosis, and arthritis.</p> <p>During the initial tour on 12-16-2015 at 4:06 AM, Resident #L was identified as not being interviewable.</p> <p>In an interview on 12-16-2015 at 6:36 AM, LPN #1 indicated she had witnessed another staff member telling Resident #L that if she did not go back to bed, her pain medication would be withheld. LPN #1 indicated she had told the Director of Nursing, but nothing had been done, and so, she didn't tell anyone else.</p> <p>In a confidential interview on 12-16-2015 at 7:38 AM, a resident, identified as interviewable on the initial tour, indicated she heard the night nurse telling</p>	R 0053	Staff re-educated on residents rights and Policy and Procedures for recognizing and reporting Abuse and Neglect conducted by Executive Director Monthly all staff in-service will include additional training on recognizing verbal abuse conducted by Executive Director for each of 12 months in 2016	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--	---	---	---

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
--------------------	--	---------------	---	----------------------

R 0306 Bldg. 00	<p>Resident #L she would not receive her pain medication in the morning if she did not go back to bed.</p> <p>A review of a current policy titled Abuse and Neglect Reporting revised 12-27-2011, provided by the Administrator on 12-16-2015 at 7:31 AM, indicated under the title "Procedure: 1. Immediately notify the incident to the Executive Director of the issue."</p> <p>This State citation is related to Complaint IN00188375.</p> <p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.</p>			
------------------------	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--	---	---	---

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>Based on interview and record review, the facility failed to follow their policy regarding narcotic destruction for 3 of 3 residents with narcotics in a sample of 7 (Resident #H, Resident #J, and Resident #N)</p> <p>Findings include:</p> <p>1. Resident #H's record was reviewed 12-16-2015 at 8:57 AM. Resident #H's diagnoses included, but were not limited to, high blood pressure, depression, and dementia.</p> <p>A review of Resident #H's drug destruction record dated 12-3-2015 indicated LPN #2 and QMA #3 flushed the Schedule II controlled substances Lorazepam [0.5 milligrams (mg)] number 30 and Roxanol [20 mg per milliliter (ml)] 28.25 ml.</p> <p>2. Resident #J's record was reviewed 12-16-2015 at 8:24 AM. Resident #J's diagnoses included, but were not limited to, high blood pressure, anxiety, and dementia.</p> <p>A review of Resident #J's drug destruction record dated 12-3-2015 indicated LPN #2 and QMA #3 flushed the Schedule II controlled substance</p>	R 0306	RN hired as DON and will be responsible for future destruction/disposal of expired or discontinued medication with the assistance of LPN New procedures are currently in place	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--	---	---	---

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>Lorazepam (0.5 mg) number 24.</p> <p>3. Resident #N's record was reviewed 12-16-2015 at 9:08 AM. Resident #N's diagnoses included, but were not limited to, dementia, glaucoma, and anemia.</p> <p>A review of Resident #N's drug destruction record dated 12-3-2015 indicated LPN #2 and QMA #3 flushed the Schedule II controlled substance Lorazepam (0.5 mg) number 24.</p> <p>In an interview on 12-17-2015 at 2:06 PM, the Director of Nursing indicated a "QMA is licensed and should be able to destroy narcotics."</p> <p>A current policy titled disposal/ Destruction of Expired or Discontinued Medications dated 1-1-2013 provided by the Director of Nursing at 12:09 PM, indicated "12. Facility should destroy Schedule II-IV controlled substances as detailed above, with the following exceptions: 12.1 Facility should destroy controlled substances in the presence of a Registered Nurse and a licensed professional in accordance with facility policy or actual law."</p> <p>This State Citation is related to Complaint IN00188375.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--	---	---	---

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
R 0349 Bldg. 00	<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 observation, interview and record review, the facility failed to accurately document fall interventions for 1 of 3 residents with falls, and family notifications for 1 of 3 residents reviewed for family notifications in a sample of 7. (Resident #M and Resident #J)</p> <p>Findings include:</p> <p>1. Resident #M's record was reviewed on 12-17-2015 at 11:51 AM. Resident #M's diagnoses included, but were not limited to, high blood pressure, psychosis with behavioral disturbances, and heart dysrhythmia.</p> <p>Resident #M's current Service Plan dated 10-2-2015 indicated alarms were to be in place to prevent falls while Resident #M was in the chair and in the bed.</p>	R 0349	<p>DON will conduct in-service training, re-educating all nursing staff on proper documentation of fall interventions; family notifications; physician notifications In-service training to be completed by DON by January 8, 2016 of all current licensed nursing staff and ongoing for all newly hired nursing staff Fall interventions will be added to service plans by DON; systematic changes have been made and are currently in place to have service plans that reflect current care needs by January 8, 2016 Don to conduct review of new orders on a routine basis to ensure staff compliance with new orders and appropriate documentation of orders; systematic changes are already in place</p>	01/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--	---	---	---

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>During an observation on 12-16-2015 at 6:00 AM, Resident #M was observed in bed. No alarm was in place.</p> <p>During an observation on 12-17-2015 at 11:56 AM, Resident #M was observed in her wheelchair in the dining room. No alarm was in place.</p> <p>In an interview on 12-17-2015 at 12:10 PM, LPN #2 indicated Resident #M's alarms had been discontinued. LPN #2 further indicated the alarms should have been removed from the Service Plan.</p> <p>2. Resident #J's record was reviewed 12-16-2015 at 8:24 AM. Resident #J's diagnoses included, but were not limited to, high blood pressure, anxiety, and dementia.</p> <p>A review of Resident #J's Nurse's Notes dated 11-2-2015 at 4:00 PM indicated Resident #J had blood in her nose and swelling to her face. The note did not indicate the family had been notified.</p> <p>A review of late entry Nurse's Notes dated 11-2-2015, did not indicate the family had been notified.</p> <p>A review of Nurse's notes dated 11-3-2015 did not indicate the family had been notified of the resident's injuries.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2015	
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>In an interview on 12-17-2015 at 10:28 AM, LPN #2 indicated Resident #J's son had been very active in her care, and he had been notified. LPN #2 indicated the notification should have been documented.</p> <p>This State Citation is related to Complaint IN00188375.</p>						